

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS 1975

HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
NINETY-FOURTH CONGRESS
FIRST AND SECOND SESSIONS
ON
S. 1926
TO AMEND TITLE XIII OF THE PUBLIC HEALTH SERVICE
ACT TO REVISE AND EXTEND THE PROGRAM FOR THE
ESTABLISHMENT AND EXPANSION OF HEALTH
MAINTENANCE ORGANIZATIONS
AND RELATED BILLS

NOVEMBER 21, 1975, DECEMBER 12, 1975, AND JANUARY 19, 1976



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1975**

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HEALTH MAINTENANCE ORGANIZATION AMENDMENTS, 1975

FRIDAY, NOVEMBER 21, 1975

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:30 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy and Schweiker.

Committee staff present: Philip Caper, M.D., professional staff member; and Jay B. Cutler, minority counsel.

Senator KENNEDY. I would like to call this meeting of the Health Subcommittee to order.

This is the first in a series of hearings into proposed amendments to the Health Maintenance Organization Act of 1973. Today's hearing will focus upon the speed, vigor, and efficiency with which the Department of Health, Education, and Welfare has implemented this complex law—a law intended to implement one of the three major initiatives in the health area described by President Nixon in 1971.

Section 1315 of the Health Maintenance Organization Act requires the Comptroller General to evaluate the progress of implementation of the HMO program, and periodically report the progress of the program to the Congress.

We shall be particularly interested today in learning about the speed with which regulations implementing this program have been developed and promulgated; the degree of commitment by the Department of Health, Education, and Welfare to the program as evidenced by the administrative structure and commitment of personnel and funds within the Department toward achieving the goals of the legislation; the development of the HMO concept as a meaningful alternative to fee-for-service medicine in communities throughout the United States.

Our first two witnesses today included representatives of the General Accounting Office, and representatives of the Department of Health, Education, and Welfare.

Senator SCHWEIKER. Mr. Chairman?

Senator KENNEDY. Senator Schweiker?

Senator SCHWEIKER. The delivery of adequate health care to our citizens is a paramount concern of this committee. Excessive expenditures under medicare and medicaid, and problems in the cost, avail-

ability, and quality of medical care have become too great for public policy to ignore.

For a time, Federal policy attempted to deal with these problems symptomatically, establishing supplemental delivery programs where care was unavailable, and financing programs for the elderly and poor. It has now become clearer that our problems stem from deeper structural deficiencies, and some of our earlier policies, while helpful in some respects, have worsened these deficiencies. With the passage of the Health Maintenance Organization Act of 1973, Public Law 93-222, the Federal Government embarked upon a new course attempting to encourage change in our health care system.

In its report on the HMO Act, the Senate Labor and Public Welfare Committee stated:

Health Maintenance Organizations assure the consumer of health services access to a wide range of necessary health services. HMO's, if effectively designed, largely eliminate many of the problems presented by the prevalent fragmented solo practice model. Too often, in the existing system of medical practice, patients must seek uncoordinated care from various specialists who may be scattered over a wide geographic area, necessitating a number of time-consuming visits to more than one doctor.

Though the Committee wishes to strongly emphasize that it does not intend to supplant existing forms of medical delivery such as solo practice, it intends to make available to all Americans a real choice with respect to the form of medical delivery they individually wish to purchase.

Like any new governmental concept, the implementation of the HMO Act has encountered difficulties. Some of these problems stem from the administration's difficulty in developing regulations which are necessary for implementation. Many, however, stem from the provisions of the law itself.

Potential HMO sponsors have been discouraged by certain restrictive provisions of the HMO law. Employers and labor unions have also publicly criticized provisions of the HMO law. After reviewing the situation, it was my opinion, along with many other Members of Congress, the administration, and many other groups and individuals, that the health maintenance organization law needs to be amended if we are to provide health maintenance organizations a fair opportunity in the medical marketplace at obtaining both health care providers and consumer acceptance.

The amendments cosponsored by Senators Javits, Mondale, and I, which embody the recommendations of the Group Health Association of America, the American Group Practice Association, the American Association of Foundations for Medical Care, Blue Cross Association, the Health Insurance Association of America, and the AFL-CIO, would improve this legislation by enhancing the ability of health maintenance organizations to market their services to the public, by making the formation of HMO's more attractive to potential sponsors, and by incorporating certain changes designed to improve the administration and flexibility of the law.

Mr. Chairman, I ask that the prepared statement of Senator Javits on the pending bill be printed at this point along with the bills and public law.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. Today's hearing focuses on a topic of overriding importance for the future of health care delivery—the HMO amendments of 1975—S. 1926—which I joined in introducing with Senators Schweiker and Mondale. S. 1926 would amend the Health Maintenance Organization Act of 1973—Public Law 93-222—a law which in great measure reflects my legislative support for HMO development, as provided for in bills I introduced, authored, and cosponsored in previous Congresses.

I have long believed in the important concept of establishing health care delivery systems that assume both financial and health service responsibility for defined populations—since all evidence indicates that they hold the best hope for providing quality comprehensive health care with cost containment.

HMO's deserve continuing congressional support and encouragement. They are the cutting edge of innovation in health care delivery, and their many forms—both group and individual practice associations—contain the seeds for fruitful experimentation and for evaluating how best to provide the total range of services that people need. To enable the fledgling HMO movement to become more competitive in the marketplace—which has heretofore been dominated by traditional health insurance systems and delivery system arrangements—it has become essential that we respond to concerns expressed regarding implementation of the HMO law—and that is the purpose of the pending bill, S. 1926.

At present, HMO's have only a very small market share—less than 10 percent—so that I am not persuaded by arguments against vigorous and continuing Federal efforts, that are described by the American Medical Association as “preferential treatment.”

However, the results of the program contemplated by the HMO law to date have been disappointing. Only about one quarter of the existing HMO's have sought financial and technical assistance to become certified under the law; and few of the 157 funded programs have gotten off the ground and into the business of providing care.

We who worked for the enactment of the HMO law must seek to end the restrictive provisions required of HMO's—and not of alternative delivery systems—because these restrictions have not allowed HMO's to prove themselves by fair competition. This is the goal of S. 1926, and the recently passed House bill, H.R. 9019.

To correct the deficiencies that hamstringing an excellent concept, and a potentially excellent program of HMO's, these amendments would provide:

- (1) An identifiable, staffed unit in HEW to administer the HMO program, and to get the program moving rapidly and effectively;
- (2) Changes in the benefit package that would allow certain services to be transferred from basic to supplemental, so that HMO's can compete in cost terms with more conventional insurance schemes;
- (3) Provisions for phasing-in of both the health services to be

provided and the enrollment of prepaid members, in order to facilitate the startup of HMO's in communities which have not had the opportunity to identify with these new forms of health care delivery;

(4) Clarification of the dual choice provisions to insure the decision respecting health care coverage options in employer-employee relations would continue through the collective bargaining process;

(5) Relieving HMO's from the requirement to provide an open enrollment period—a requirement not imposed on other health insurance schemes. This would shield HMO's from the danger of adverse risk selection that could threaten their financial viability;

(6) Strengthened provision for assistance, loans, and loan guarantees to HMO's that serve medically underserved populations.

While I support all the principles underlying these amendments, it is important to evaluate them critically and effectively:

While HMO's need relief in tailoring the benefit package to compete in the marketplace, I favor retention in the basic benefits package of the drug and alcohol abuse referral. These referral services, to existing community facilities for treatment, should continue and would not, in my judgment, place undue cost burdens on HMO's.

While sympathetic to the need to relieve HMO's of the present open enrollment period, and of the requirement—contained in HEW regulations—that more than half of patients in the system be prepaid enrollees, at the same time, I am convinced that this would best be achieved in another fashion. I would suggest the development of performance standards to assure that HMO's are meeting their responsibility to provide community service. If we develop such standards, that is, specify the criteria under which the Secretary can waive open enrollment and the criteria for substantial commitment to increasing the proportion of prepaid enrollees—the law per se will recognize that it will take HMO's time to gain acceptance in many communities.

I am confident that the committee will give careful consideration to the testimony and develop criteria that are appropriate to allowing HMO's to grow, while at the same time maintaining public accountability.

[A copy of S. 1926, H.R. 9019, and Public Law 93-222 follow:]

S. 1926

IN THE SENATE OF THE UNITED STATES

JUNE 12 (legislative day, JUNE 6), 1975

Mr. SCHWEIKER (for himself, Mr. JAVITS, and Mr. MONDALE) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That (a) this Act may be cited as the "Health Maintenance
4 Organization Amendments of 1975".

5 (b) Whenever in this Act an amendment or repeal is
6 expressed in terms of an amendment to, or repeal of, a
7 section or other provision, the reference shall be considered
8 to be made to a section or other provision of the Public
9 Health Service Act.

1 SEC. 2. The first sentence of section 1301 (b) (2) is
2 amended by striking out "the organization shall provide"
3 and all that follows in that sentence and inserting in lieu
4 thereof "the organization may provide to each of its members
5 any of the health services which are included in supplemental
6 health services (as defined in section 1302 (2)) .".

7 SEC. 3. (a) The first sentence of section 1301 (b) (3)
8 is amended (1) by striking out "or through" and inserting in
9 lieu thereof ", through", and (2) by inserting after "(or
10 associations)" the following: ", or under arrangements with
11 health professionals who have contracted with the health
12 maintenance organization for the provision of such services".

13 (b) Section 1310 (b) (2) is amended by inserting after
14 "(or associations)" the following: "or under arrangements
15 with health professionals who have contracted with such or-
16 ganizations for the provisions of such services".

17 SEC. 4. Section 1301 (c) is amended (1) by striking out
18 paragraph (4), and (2) by redesignating paragraphs (5),
19 (6), (7), (8), (9), (10), and (11) as paragraphs (4),
20 (5), (6), (7), (8), (9), and (10), respectively.

21 SEC. 5. (a) Paragraph (1) of section 1302 is amended—
22 (1) by striking out subparagraphs (E) and (G),
23 (2) by inserting "and" at the end of subparagraph
24 (F),

1 (3) by redesignating subparagraphs (F) and (H)
2 as subparagraphs (E) and (F), respectively,

3 (4) by amending subparagraph (F) (as so reded-
4 ignated) to read as follows:

5 “(F) the following preventive health services: (i)
6 Immunizations, (ii) well-child care from birth, (iii)
7 periodic health evaluations for adults, (iv) voluntary
8 family planning services, (v) infertility services, and
9 (vi) children’s eye examinations conducted to deter-
10 mine the need for vision correction.”,

11 (5) by striking out “or podiatrist” each place it
12 occurs and inserting in lieu thereof “podiatrists, or other
13 health care personnel”, and

14 (6) by striking out the next to last sentence.

15 (b) Paragraph (2) of such section is amended—

16 (1) by striking out “(1) (A) or (1) (H)” in
17 subparagraph (B) and inserting in lieu thereof “(1)
18 (F)”,

19 (2) by striking out “not included as a basic health
20 service under paragraph (1) (A) or (1) (H)” in sub-
21 paragraph (C),

22 (3) by striking out “and” at the end of subpara-
23 graph (E), by striking out the period at the end of
24 subparagraph (F) and inserting in lieu thereof a semi-

1 colon, and by adding after subparagraph (F) the fol-
2 lowing:

3 “(G) home health services;

4 “(H) referral services and medical treatment for
5 the abuse of or addiction to alcohol or drugs; and

6 “(I) other health services which are not included as
7 basic health services and which have been approved by
8 the Secretary for delivery as supplemental health
9 services.”,

10 (4) by striking out “or podiatrists” each place it
11 occurs and inserting in lieu thereof “podiatrist, or other
12 health care personnel”, and

13 (5) by inserting before the last sentence the fol-
14 lowing: “For purposes of this paragraph, the term
15 ‘home health services’ means health services provided
16 at a member’s home by health care personnel, as pre-
17 scribed or directed by the responsible physician or other
18 authority designated by the health maintenance
19 organization.

20 SEC. 6. (a) (1) Section 1301(b) (1) is amended by
21 adding at the end thereof the following new sentence: “The
22 requirement of clause (C) of the first sentence shall apply
23 with respect to a health maintenance organization on and
24 after the expiration of the sixty-month period beginning after
25 the date the organization becomes a qualified health main-

1 tenance organization (within the meaning of section 1310
2 (d)).”.

3 (2) The last sentence of section 1301 (b) (2) is
4 amended by inserting after “shall” the following: “, on and
5 after the expiration of the sixty-month period beginning after
6 the date the organization providing the services becomes a
7 qualified health maintenance organization (within the
8 meaning of section 1310 (d)),”.

9 (3) Section 1306 (b) is amended (A) by striking out
10 “and” at the end of paragraph (6), (B) by redesignating
11 paragraph (7) as paragraph (8), and (C) by inserting
12 after paragraph (6) the following new paragraph:

13 “(7) the application contains such assurances as
14 the Secretary may require respecting the intent and the
15 ability of the applicant to meet the requirements of
16 paragraphs (1) and (2) of section 1301 (b) respecting
17 the fixing of basic health services payments and supple-
18 mental health services payments under a community
19 rating system; and”.

20 (b) Section 1302 (8) (A) is amended by inserting
21 “differences in marketing costs and” after “reflect”.

22 SEC. 7. Section 1302 (4) (C) (i) is amended by strik-
23 ing out “for a health maintenance organization”.

24 SEC. 8. (a) Section 1304 (a) (2) is amended (1) by
25 striking out “(other than nonprofit private entities)”, and

1 (2) by striking out “to serve medically underserved popu-
2 lations”.

3 (b) Section 1304(b) (1) (B) is amended (1) by
4 striking out “(other than a nonprofit private entity)”, and
5 (2) by striking out “which will serve a medically under-
6 served population”.

7 (c) Section 1305(a) (3) is amended (1) by striking
8 out “(other than a private nonprofit health maintenance or-
9 ganization)”, and (2) by striking out “, but only if such
10 health maintenance organization will serve a medically un-
11 derserved population”.

12 (d) (1) Section 1304(d) is amended by adding at the
13 end the following new sentence: “In considering applications
14 for loan guarantees under this section, the Secretary shall
15 give special consideration to applications for projects for
16 health maintenance organizations which will serve medically
17 underserved populations.”.

18 (2) Section 1305 is amended by adding at the end there-
19 of the following new subsection:

20 “(f) In considering applications for loan guarantees
21 under this section, the Secretary shall give special considera-
22 tion to applications for health maintenance organizations
23 which will serve medically underserved populations.”.

1 SEC. 9. (a) (1) Section 1305 (a) is amended by strik-
2 ing out "in the period of" in paragraphs (1) and (2) and
3 inserting in lieu thereof "during a period not to exceed".

4 (2) The last sentence of 1305 (b) (1) is amended to
5 read as follows: "In any fiscal year the amount disbursed
6 to a health maintenance organization under this section
7 (either directly by the Secretary or by an escrow agent
8 under the terms of an escrow agreement or by a lender
9 under a loan guaranteed under this section) may not exceed
10 \$1,000,000."

11 (b) Section 1307 (e) is amended—

12 (1) by inserting "for a private health maintenance
13 organization (other than a private nonprofit health
14 maintenance organization)" after "may be made", and

15 (2) by inserting "for private health maintenance
16 organizations (other than private nonprofit health
17 maintenance organizations)" after "guaranteed".

18 (c) (1) Section 1308 (a) (1) (A) is amended by strik-
19 ing out "for similar loans" and inserting in lieu thereof
20 "for loans with similar maturities, terms, conditions, and
21 security".

22 (2) Section 1308 (b) (2) (D) is amended by striking
23 out "loans guaranteed under this title" and inserting in lieu
24 thereof "marketable obligations of the United States of

1 comparable maturities, adjusted to provide for appropriate
2 administrative charges”.

3 SEC. 10. Section 1310 is amended—

4 (1) by amending subsection (a) to read as follows:

5 “(a) Each employer which is now or hereafter required
6 during any calendar quarter to pay its employees the mini-
7 mum wage specified by section 6 of the Fair Labor Standards
8 Act of 1938 (or would be required to pay its employees
9 such wage but for section 13 (a) of such Act), and which
10 during such calendar quarter employed an average number
11 of employees of not less than twenty-five, shall, in accordance
12 with regulations which the Secretary shall prescribe, include
13 in any health benefits plan offered to its employees in the
14 calendar year beginning after such calendar quarter the
15 option of membership in qualified health maintenance
16 organizations which are engaged in the provision of basic
17 and supplemental health services in health maintenance
18 organization service areas in which at least twenty-five of
19 such employees reside.”.

20 (2) by striking out the last sentence of subsection
21 (c), and

22 (3) by adding after subsection (d) the following
23 new subsection:

24 “(e) (1) (A) Any employer who fails to comply with
25 the requirements of subsection (a) shall be subject to a

1 civil penalty of not more than \$10,000. Such penalty may
2 be assessed by the Secretary and collected in a civil action
3 brought by the United States in a United States district
4 court.

5 “(2) In any proceeding by the Secretary to assess a
6 civil penalty under this subsection, no penalty shall be
7 assessed until the employer charged shall have been given
8 notice and an opportunity to present its views on such
9 charge. In determining the amount of the penalty, or the
10 amount agreed upon in compromise, the Secretary shall
11 consider the gravity of the noncompliance and the demon-
12 strated good faith of the employer charged in attempting
13 to achieve rapid compliance after notification by the Secre-
14 tary of a noncompliance.

15 “(3) In the case of any civil penalty assessed against
16 any employer by the Secretary under this subsection, if the
17 Secretary’s determination that such person is liable for such
18 penalty is made on the record after notice and opportunity
19 for hearing, then in any civil action to collect such penalty
20 (and in any other civil action reviewing such determination
21 of the Administrator) any findings of fact on which such
22 determination is based shall be conclusive if supported by
23 substantial evidence on the record considered as a whole.

24 “(f) The term ‘employer’, as used in this subsection,

1 does not include a department, agency, or instrumentality
2 of the United States.”.

3 SEC. 11. Section 1312 is amended by striking out all of
4 the section following paragraph (3) of subsection (a) and
5 inserting in lieu thereof the following: “the Secretary may
6 take the action authorized by subsection (b) .

7 “(b) (1) If the Secretary makes, with respect to any
8 entity which provided assurances to the Secretary under
9 section 1310 (d) (1), a determination described in subsec-
10 tion (a), the Secretary shall notify the entity in writing of
11 the determination. Such notice shall specify the manner in
12 which the entity has not complied with such assurances and
13 direct that the entity initiate (within thirty days of the date
14 the notice is issued by the Secretary or within such longer
15 period as the Secretary determines is reasonable) such action
16 as may be necessary to bring (within such period as the Sec-
17 retary shall prescribe) the entity into compliance with the
18 assurances. If the entity fails to initiate corrective action
19 within the period prescribed by the notice or fails to comply
20 with the assurances within such period as the Secretary pre-
21 scribes (A) the entity shall not be a qualified health main-
22 tenance organization for purposes of section 1310 until such
23 date as the Secretary determines that it is in compliance with
24 the assurances, and (B) each employer which has offered
25 membership in the entity in compliance with section 1310

1 shall be notified by the entity that the entity is not a qualified
2 health maintenance organization for purposes of such section.
3 The Secretary shall publish in the Federal Register each de-
4 termination referred to in clause (A) of the preceding
5 sentence.

6 “(2) If the Secretary makes, with respect to an entity
7 which has received a grant, contract, loan, or loan guarantee
8 under this title, a determination described in subsection (a)
9 the Secretary may, in addition to any other remedies avail-
10 able to him, bring a civil action in the United States district
11 court for the district in which such entity is located to enforce
12 its compliance with the assurances it furnished respecting the
13 provision of basic and supplemental health services or its
14 organization or operation, as the case may be, which assur-
15 ances were made in connection with its application under
16 this title for the grant, contract, loan, or loan guarantee.”.

17 SEC. 12. Section 1307 (d) is amended by adding after
18 and below paragraph (2) the following new sentence:
19 “An entity which provides health services to a defined pop-
20 ulation on a prepaid basis and which has members who are
21 enrolled under the health benefits program authorized by
22 chapter 89 of title 5, United States Code, may be considered
23 as a health maintenance organization for purposes of receiv-
24 ing assistance under this title if with respect to its other
25 members it provides health services in accordance with sec-

1 tion 1301 (b) and is organized and operated in the manner
2 prescribed by section 1301 (c).”.

3 SEC. 13. (a) (1) Subsection (j) of section 1304 is
4 amended (A) by striking out “the fiscal year ending
5 June 30, 1976” and inserting in lieu thereof “fiscal year
6 1978”, and (B) by striking out “the fiscal year ending
7 June 30, 1977” and inserting in lieu thereof “fiscal year
8 1979”.

9 (2) Subsection (k) (1) of such section is amended by
10 striking out “June 30, 1975” and inserting in lieu thereof
11 “or in either of the next three fiscal years”.

12 (3) Subsection (k) (2) of such section is amended by
13 striking out “two fiscal years” and inserting in lieu thereof
14 “four fiscal years”.

15 (b) Subsection (d) of section 1305 is amended to
16 read as follows:

17 “(d) No loan may be made or guaranteed under this
18 section after September 30, 1980.”.

19 (c) Section 1309 (a) is amended—

20 (1) by striking out “for the fiscal year ending
21 June 30, 1976” and inserting in lieu thereof “each
22 for the fiscal years 1976, 1977, and 1978”; and

23 (2) by striking out “for the fiscal year ending
24 June 30, 1977” and inserting in lieu thereof “for fiscal
25 year 1979”.

1 SEC. 14. (a) The amendments made by sections 2, 3, 4,
2 5, and 7 shall (1) apply with respect to grants, contracts,
3 loans, and loan guarantees made under sections 1303, 1304,
4 and 1305 of the Public Health Service Act for fiscal years
5 beginning after June 30, 1975, (2) apply with respect to
6 health benefit plans offered under section 1310 of such Act
7 after such date, and (3) for purposes of section 1312 take
8 effect July 1, 1975.

9 (b) The amendments made by sections 9(a) (1) and
10 9(c) shall apply with respect to loans and loan guarantees
11 made under section 1305 of the Public Health Service Act
12 after June 30, 1975.

13 (c) (1) The amendment made by paragraph (1) of
14 section 10 shall apply with respect to calendar quarters which
15 begin after the date of the enactment of this Act.

16 (2) The amendments made by paragraphs (2) and (3)
17 of section 10 shall apply with respect to failures of employers
18 to comply with section 1310(a) of the Public Health Serv-
19 ice Act after the date of the enactment of this Act.

20 (d) The amendment made by section 11 shall apply
21 with respect to determinations of the Secretary of Health,
22 Education, and Welfare described in section 1312(a) of the
23 Public Health Service Act and made after the date of the
24 enactment of this Act.

94TH CONGRESS
1ST SESSION

H. R. 9019

IN THE SENATE OF THE UNITED STATES

NOVEMBER 10, 1975

Read twice and referred to the Committee on Labor and Public Welfare

AN ACT

To amend title XIII of the Public Health Service Act to revise and extend the program for the establishment and expansion of health maintenance organizations.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That (a) this Act may be cited as the "Health Maintenance
4 Organization Amendments of 1975".

5 (b) Unless otherwise expressly provided, whenever in
6 this Act an amendment or repeal is expressed in terms of an
7 amendment to, or repeal of, a section or other provision, the
8 reference shall be considered to be made to a section or other
9 provision of the Public Health Service Act.

1 SEC. 2. (a) Section 1301 (b) (1) is amended by add-
2 ing at the end the following: "A health maintenance orga-
3 nization may include a health service, defined as a supple-
4 mental health service by section 1302 (2), in the basic
5 health services provided its members for a basic health
6 services payment described in the first sentence."

7 (b) The first sentence of section 1301 (b) (2) is
8 amended by striking out "the organization shall provide"
9 and all that follows in that sentence and inserting in lieu
10 thereof "the organization may provide to each of its mem-
11 bers any of the health services which are included in supple-
12 mental health services (as defined in section 1302 (2)) .".

13 (c) Section 1301 (b) (4) is amended by striking out
14 "and supplemental health services in the case of the mem-
15 bers who have contracted therefor" and inserting in lieu
16 thereof "and only such supplemental health services as mem-
17 bers have contracted for".

18 SEC. 3. (a) (1) The first sentence of section 1301 (b)
19 (3) is amended (A) by striking out "or through" and in-
20 serting in lieu thereof ", through", (B) by striking out
21 "(or groups) or" and inserting in lieu thereof "(or groups),
22 through an", and (C) by inserting after "(or associations)"
23 the following: ", through health professionals who have
24 contracted with the health maintenance organization for the
25 provision of such services, or through any combination of

1 such staff, medical group (or groups), individual practice
2 association (or associations), or health professionals under
3 contract with the organization”.

4 (2) Section 1301 (b) (3) is amended by adding after
5 the first sentence the following: “The services of the health
6 professionals providing basic health services shall include
7 available and appropriate services of professional personnel,
8 allied health professions personnel, and other health person-
9 nel (as specified in regulations of the Secretary) for the
10 effective and efficient delivery of the basic health services.
11 A health maintenance organization may also, during the
12 sixty-month period beginning after the date the organiza-
13 tion becomes a qualified health maintenance organization
14 (within the meaning of section 1310 (d)), provide basic
15 health services through an entity which but for the require-
16 ment of section 1302 (4) (C) (i) would be a medical group
17 for purposes of this title. After the expiration of such period,
18 the organization may provide such services through such an
19 entity only if authorized by the Secretary in accordance with
20 regulations. Contracts between a health maintenance organi-
21 zation and health professionals for the provision of basic
22 health services shall include such provisions as the Secretary
23 may require (including provisions requiring appropriate con-
24 tinuing education).”.

25 (b) (1) Section 1302 (4) (C) is amended (A) by

1 striking out clause (iv), (B) by redesignating clause (v) as
2 clause (iv), and (C) by inserting "and" at the end of
3 clause (iii).

4 (2) Section 1302 (5) (B) is amended (A) by striking
5 out clause (i), and (B) by redesignating clauses (ii) and
6 (iii) as clauses (i) and (ii), respectively.

7 (c) (1) Section 1310 (b) (1) is amended to read as
8 follows:

9 " (1) one or more of such organizations provides
10 basic health services (A) without the use of an individ-
11 ual practice association and (B) without the use of con-
12 tracts (except for contracts for unusual or infrequently
13 used services) with health professionals; and".

14 (2) Section 1310 (b) (2) is amended to read as follows:

15 " (2) one or more of such organizations provides
16 basic health services through (A) an individual practice
17 association (or associations), (B) health professionals
18 who have contracted with the health maintenance organi-
19 zation for the provision of such services, or (C) a com-
20 bination of such association (or associations) or health
21 professionals under contract with the organization,".

22 SEC. 4. Section 1301 (c) is amended (1) by striking out
23 paragraph (4), and (2) by redesignating paragraphs
24 (5), (6), (7), (8), (9), (10), and (11) as paragraphs
25 (4), (5), (6), (7), (8), (9), and (10), respectively.

1 SEC. 5. (a) Paragraph (1) of section 1302 is amended—

2 (1) by striking out subparagraph (E),

3 (2) by redesignating subparagraphs (F), (G),
4 and (H) as subparagraphs (E), (F), and (G), respec-
5 tively.

6 (3) by amending subparagraph (G) (as so re-
7 designated) to read as follows:

8 “(G) preventive health services (including (i)
9 immunizations, (ii) well-child care from birth, (iii)
10 periodic health evaluations for adults, (iv) voluntary
11 family planning services, (v) infertility services, and
12 (vi) children’s eye and ear examinations conducted to
13 determine the need for vision and hearing correction).”,
14 and

15 (4) by striking out “or podiatrist” each place it
16 occurs and inserting in lieu thereof “podiatrist, or other
17 health care personnel”.

18 (b) Paragraph (2) of such section is amended—

19 (1) by striking out “(1) (A) or (1) (H)” in sub-
20 paragraphs (B) and (C) and inserting in lieu thereof
21 “(1) (G)”,

22 (2) by striking out “and” at the end of subpara-
23 graph (E), by striking out the period at the end of sub-
24 paragraph (F) and inserting in lieu thereof a semicolon,
25 and by adding after subparagraph (F) the following:

1 “(G) referral services and medical treatment for
2 the abuse of or addiction to alcohol or drugs; and

3 “(H) other health services which are not included
4 as basic health services and which have been approved
5 by the Secretary for delivery as supplemental health
6 services.”, and

7 (3) by striking out “or podiatrist” each place it
8 occurs and inserting in lieu thereof “podiatrist, or other
9 health care personnel”.

10 SEC. 6. (a) (1) Section 1301 (b) (1) is amended by
11 adding at the end thereof the following new sentence: “The
12 requirement of clause (C) of the first sentence shall apply
13 with respect to a health maintenance organization on and
14 after the expiration of the sixty-month period beginning
15 after the date the organization becomes a qualified health
16 maintenance organization (within the meaning of section
17 1310 (d)).”.

18 (2) The last sentence of section 1301 (b) (2) is
19 amended by inserting after “shall” the following: “, on and
20 after the expiration of the sixty-month period beginning
21 after the date the organization providing the services be-
22 comes a qualified health maintenance organization (within
23 the meaning of section 1310 (d)),”.

24 (3) Section 1306 (b) is amended (A) by striking out
25 “and” at the end of paragraph (6), (B) by redesignating

1 paragraph (7) as paragraph (8), and (C) by inserting
2 after paragraph (6) the following new paragraph:

3 “(7) the application contains such assurances as
4 the Secretary may require respecting the intent and the
5 ability of the applicant to meet the requirements of
6 paragraphs (1) and (2) of section 1301 (b) respecting
7 the fixing of basic health services payments and sup-
8 plemental health services payments under a community
9 rating system; and”

10 (b) Section 1302 (8) (A) is amended by inserting
11 “differences in marketing costs and” after “reflect”.

12 SEC. 7. (a) Section 1304 (a) (2) is amended to read as
13 follows:

14 “(2) guarantee to non-Federal lenders payment of
15 the principal of and the interest on loans made to—

16 “(A) nonprofit private entities for planning
17 projects for the establishment or expansion of health
18 maintenance organizations, or

19 “(B) other private entities for such projects for
20 health maintenance organizations to serve medically
21 underserved populations.”.

22 (b) Section 1304 (b) (1) (B) is amended to read as
23 follows:

24 “(B) guarantee to non-Federal lenders payment of
25 the principal of and the interest on loans made to—

1 “(i) nonprofit private entities for projects for
2 the initial development of health maintenance
3 organizations, or

4 “(ii) other private entities for such projects
5 for health maintenance organizations which will
6 serve medically underserved populations.”.

7 (c) Section 1305 (a) (3) is amended to read as follows:

8 “(3) guarantee to non-Federal lenders payment of
9 the principal of and the interest on loans made to—

10 “(A) nonprofit private health maintenance or-
11 ganizations for the amounts referred to in paragraph
12 (1) or (2), or

13 “(B) other private health maintenance orga-
14 nizations for such amounts but only if the health
15 maintenance organization will serve a medically
16 underserved population.”.

17 (d) (1) Section 1304 (d) is amended by adding at the
18 end the following new sentence: “In considering applications
19 for loan guarantees under this section, the Secretary shall
20 give special consideration to applications for projects for
21 health maintenance organizations which will serve medically
22 underserved populations.”.

23 (2) Section 1305 is amended by adding at the end
24 thereof the following new subsection:

25 “(f) In considering applications for loan guarantees

1 under this section, the Secretary shall give special considera-
2 tion to applications for health maintenance organizations
3 which will serve medically underserved populations.”.

4 SEC. 8. (a) (1) Section 1305 (a) is amended by strik-
5 ing out “in the period of” in paragraphs (1) and (2) and
6 inserting in lieu thereof “during a period not to exceed”.

7 (2) The last sentence of 1305 (b) (1) is amended to
8 read as follows: “In any fiscal year the amount disbursed
9 to a health maintenance organization under this section
10 (either directly by the Secretary or by an escrow agent
11 under the terms of an escrow agreement or by a lender under
12 a loan guaranteed under this section) may not exceed
13 \$1,000,000.”.

14 (b) (1) Section 1307 (e) is amended—

15 (A) by inserting “for a private health maintenance
16 organization (other than a private nonprofit health
17 maintenance organization)” after “may be made”, and

18 (B) by inserting “for private health maintenance
19 organizations (other than private nonprofit health main-
20 tenance organizations)” after “guaranteed”.

21 (2) Section 1308 (c) is amended by adding after para-
22 graph (4) the following new paragraph:

23 “(5) Any reference in this title (other than in this
24 subsection) to a loan guarantee under this title does not in-
25 clude a loan guarantee made under this subsection.”.

1 (c) (1) Section 1308 (a) (1) (A) is amended by strik-
2 ing out "for similar loans" and inserting in lieu thereof "for
3 loans with similar maturities, terms, conditions, and secu-
4 rity".

5 (2) Section 1308 (b) (2) (D) is amended by striking
6 out "loans guaranteed under this title" and inserting in lieu
7 thereof "marketable obligations of the United States of com-
8 parable maturities, adjusted to provide for appropriate ad-
9 ministrative charges".

10 SEC. 9. (a) Section 1310 is amended—

11 (1) by amending subsection (a) to read as follows:

12 "(a) (1) Each employer which is now or hereafter re-
13 quired during any calendar quarter to pay its employees the
14 minimum wage specified by section 6 of the Fair Labor
15 Standards Act of 1938 (or would be required to pay its
16 employees such wage but for section 13 (a) of such Act), and
17 which during such calendar quarter employed an average
18 number of employees of not less than twenty-five, shall, in
19 accordance with regulations which the Secretary shall pre-
20 scribe, include in any health benefits plan offered to its
21 employees in the calendar year beginning after such calen-
22 dar quarter the option of membership in qualified health
23 maintenance organizations which are engaged in the provi-
24 sion of basic health services in health maintenance organiza-

1 tion service areas in which at least twenty-five of such
2 employees reside.

3 “(2) If any of the employees of an employer described
4 in paragraph (1) are represented by a collective bargaining
5 representative or other employee representative designated
6 or selected under any law, offer of membership in a qualified
7 health maintenance organization required by paragraph (1)
8 to be made in a health benefits plan offered to such em-
9 ployees (A) shall first be made to such collective bargaining
10 representative or other employee representative, and (B) if
11 such offer is accepted, shall then be made to each such
12 employee.”;

13 (2) by striking out the last sentence of subsection
14 (c); and

15 (3) by adding after subsection (d) the following
16 new subsections:

17 “(e) (1) Any employer who knowingly does not com-
18 ply with one or more of the requirements of subsection (a)
19 shall be subject to a civil penalty of not more than \$10,000.
20 If such noncompliance continues, a civil penalty may be
21 assessed and collected under this subsection for each thirty-
22 day period such noncompliance continues. Such penalty may
23 be assessed by the Secretary and collected in a civil action

1 brought by the United States in a United States district
2 court.

3 “(2) In any proceeding by the Secretary to assess a
4 civil penalty under this subsection, no penalty shall be as-
5 sessed until the employer charged shall have been given no-
6 tice and an opportunity to present its views on such charge.
7 In determining the amount of the penalty, or the amount
8 agreed upon in compromise, the Secretary shall consider the
9 gravity of the noncompliance and the demonstrated good
10 faith of the employer charged in attempting to achieve rapid
11 compliance after notification by the Secretary of a non-
12 compliance.

13 “(3) In any civil action brought to review the assess-
14 ment of a civil penalty assessed under this subsection, the
15 court shall, at the request of any party to such action, hold a
16 trial de novo on the assessment of such civil penalty and in
17 any civil action to collect such a civil penalty, the court shall,
18 at the request of any party to such action, hold a trial de novo
19 on the assessment of such civil penalty unless in a prior civil
20 action to review the assessment of such penalty the court held
21 a trial de novo on such assessment.

22 “(f) For purposes of this section, the term ‘employer’
23 does not include the Government of the United States, the
24 government of the District of Columbia or any territory or
25 possession of the United States, or any agency or instru-

1 mentality (including the United States Postal Service and
2 Postal Rate Commission) of any of the foregoing.”.

3 (b) Section 8902 of title 5, United States Code, relat-
4 ing to Federal employee health insurance, is amended by
5 adding at the end thereof the following new subsection:

6 “(1) The Commission shall contract under this chapter
7 for a plan described in section 8903 (4) of this title with any
8 qualified health maintenance carrier which offers such a plan.
9 For the purpose of this subsection, ‘qualified health mainte-
10 nance carrier’ means any qualified carrier which is a quali-
11 fied health maintenance organization within the meaning of
12 section 1310 (d) (1) of title XIII of the Public Health
13 Service Act (42 U.S.C. 300e-9 (d)).”.

14 SEC. 10. Section 1312 is amended by striking out all of
15 the section following paragraph (3) of subsection (a) and
16 inserting in lieu thereof the following: “the Secretary may
17 take the action authorized by subsection (b).

18 “(b) (1) If the Secretary makes, with respect to any
19 entity which provided assurances to the Secretary under
20 section 1310 (d) (1), a determination described in subsection
21 (a), the Secretary shall notify the entity in writing of the
22 determination. Such notice shall specify the manner in which
23 the entity has not complied with such assurances and direct
24 that the entity initiate (within thirty days of the
25 date the notice is issued by the Secretary or within such

1 longer period as the Secretary determines is reasonable)
2 such action as may be necessary to bring (within such
3 period as the Secretary shall prescribe) the entity into
4 compliance with the assurances. If the entity fails to initiate
5 corrective action within the period prescribed by the notice
6 or fails to comply with the assurances within such period
7 as the Secretary prescribes (A) the entity shall not be
8 a qualified health maintenance organization for purposes
9 of section 1310 until such date as the Secretary determines
10 that it is in compliance with the assurances, and (B) each
11 employer which has offered membership in the entity in
12 compliance with section 1310, each lawfully recognized
13 collective-bargaining representative or other employee rep-
14 resentative which represents the employees of each such
15 employer, and the members of such entity shall be notified
16 by the entity that the entity is not a qualified health main-
17 tenance organization for purposes of such section. The
18 notice required by clause (B) of the preceding sentence
19 shall contain, in readily understandable language, the rea-
20 sons for the determination that the entity is not a qualified
21 health maintenance organization. The Secretary shall pub-
22 lish in the Federal Register each determination referred
23 to in clause (A) of the preceding sentence.

24 “(2) If the Secretary makes, with respect to an
25 entity which has received a grant, contract, loan, or loan

1 guarantee under this title, a determination described in sub-
2 section (a), the Secretary may, in addition to any other
3 remedies available to him, bring a civil action in the United
4 States district court for the district in which such entity is
5 located to enforce its compliance with the assurances it
6 furnished respecting the provision of basic and supplemental
7 health services or its organization or operation, as the case
8 may be, with assurances were made in connection with its
9 application under this title for the grant, contract, loan, or
10 loan guarantee.

11 “(c) The Secretary, through the Assistant Secretary for
12 Health, shall administer subsections (a) and (b) in the
13 Office of such Assistant Secretary.”.

14 SEC. 11. Section 1307 (d) is amended by adding after
15 and below paragraph (2) the following new sentence: “An
16 entity which provides health services to a defined population
17 on a prepaid basis and which has members who are enrolled
18 under the health benefits program authorized by chapter 89
19 of title 5, United States Code, may be considered as a health
20 maintenance organization for purposes of receiving assistance
21 under this title if with respect to its other members it provides
22 health services in accordance with section 1301 (b) and is
23 organized and operated in the manner prescribed by section
24 1301 (c).”.

25 SEC. 12. (a) (1) Subsection (j) of section 1304 is

1 amended (A) by striking out “the fiscal year ending June
2 30, 1976” and inserting in lieu thereof “fiscal year 1978”,
3 and (B) by striking out “the fiscal year ending June 30,
4 1977” and inserting in lieu thereof “fiscal year 1979”.

5 (2) Subsection (k) (1) of such section is amended by
6 striking out “June 30, 1975” and inserting in lieu thereof
7 “or either of the next three fiscal years”.

8 (3) Subsection (k) (2) of such section is amended by
9 striking out “two fiscal years” and inserting in lieu thereof
10 “four fiscal years”.

11 (b) Subsection (d) of section 1305 is amended to read
12 as follows:

13 “(d) No loan may be made or guaranteed under this
14 section after September 30, 1980.”.

15 (c) Section 1309 (a) is amended—

16 (1) by striking out “and” after “1975.”,

17 (2) by inserting after “1976” the following: “,
18 \$45,000,000 for fiscal year 1977, and \$40,000,000 for
19 fiscal year 1978”,

20 (3) by striking out “ending June 30, 1977” and in-
21 serting in lieu thereof “1979”, and

22 (4) by striking out “\$85,000,000” the first time it
23 occurs and inserting in lieu thereof “\$45,000,000”, and
24 by striking out “\$85,000,000” the second time it occurs
25 and inserting in lieu thereof “\$40,000,000”.

1 SEC. 13. Section 1311 is amended by adding at the end
2 the following new subsection:

3 “(c) Within six months of the date of the enactment of
4 the Health Maintenance Organization Amendments of 1975,
5 the Secretary shall, if any State by law, regulation, or other-
6 wise imposes a requirement described in paragraph (1) of
7 subsection (a) or by law prevents the solicitation of members
8 in the manner described in subsection (b), notify the Gov-
9 ernor of each such State of (1) each such requirement which
10 the Secretary determines the State imposes, and (2) any
11 law which has the effect described in subsection (b).”.

12 SEC. 14. Title XIII is amended by adding after section
13 1315 the following new section:

14 “ADMINISTRATION OF PROGRAM

15 “SEC. 1316. The Secretary shall administer this title
16 (other than sections 1310 and 1312) through a single iden-
17 tifiable administrative unit of the Department.”.

18 SEC. 15. (a) The amendments made by sections 2, 3, 4,
19 and 5 shall (1) apply with respect to grants, contracts,
20 loans, and loan guarantees made under sections 1303, 1304,
21 and 1305 of the Public Health Service Act for fiscal years
22 beginning after June 30, 1975, (2) apply with respect to
23 health benefit plans offered under section 1310 of such Act
24 after such date, and (3) for purposes of section 1312 take
25 effect July 1, 1975.

1 (b) The amendments made by sections 8(a)(1) and
2 8(c) shall apply with respect to loans and loan guarantees
3 made under section 1305 of the Public Health Service Act
4 after June 30, 1975.

5 (c)(1) The amendment made by paragraph (1) of
6 section 9(a) shall apply with respect to calendar quarters
7 which begin after the date of the enactment of this Act.

8 (2) The amendments made by paragraphs (2) and (3)
9 of section 9(a) shall apply with respect to failures of em-
10 ployers to comply with section 1310(a) of the Public
11 Health Service Act after the date of the enactment of this
12 Act.

13 (3) The amendment made by section 9(b) shall take
14 effect on the date of the enactment of this Act.

15 (d) The amendment made by section 10 shall apply
16 with respect to determinations of the Secretary of Health,
17 Education, and Welfare described in section 1312(a) of the
18 Public Health Service Act and made after the date of the
19 enactment of this Act.

20 SEC. 16. So much of section 1314(a) as precedes para-
21 graph 1 thereof is amended to read as follows:

22 “SEC. 1314. (a) The Comptroller General shall evaluate
23 the operations of at least 10 or one-half, whichever is greater,
24 of the health maintenance organizations for which assistance
25 was provided under section 1303, 1304, or 1305, and which

1 have been designated by the Secretary as qualified health
2 maintenance organizations by December 31, 1976, in the
3 manner prescribed in section 1310 (d). The Comptroller
4 General shall report to the Congress the results of the evalua-
5 tion by June 30, 1977. Such report shall contain findings—”.

Passed the House of Representatives November 7,
1975.

Attest:

W. PAT JENNINGS,

Clerk.



Public Law 93-222
93rd Congress, S. 14
December 29, 1973

An Act

87 STAT. 914

To amend the Public Health Service Act to provide assistance and encouragement for the establishment and expansion of health maintenance organizations, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act, with the following table of contents, may be cited as the "Health Maintenance Organization Act of 1973".

Health Maintenance Organization Act of 1973.

TABLE OF CONTENTS

Sec. 1. Short title and table of contents.

Sec. 2. Health maintenance organizations.

"TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

"Sec. 1301. Requirements for health maintenance organizations.

"Sec. 1302. Definitions.

"Sec. 1303. Grants and contracts for feasibility surveys.

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"Sec. 1305. Loans and loan guarantees for initial operation costs.

"Sec. 1306. Application requirements.

"Sec. 1307. Administration of assistance programs.

"Sec. 1308. General provisions relating to loan guarantees and loans.

"Sec. 1309. Authorizations of appropriations.

"Sec. 1310. Employees' health benefits plans.

"Sec. 1311. Restrictive State laws and practices.

"Sec. 1312. Continued regulation of health maintenance organizations.

"Sec. 1313. Limitation on source of funding for health maintenance organizations.

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Sec. 3. Quality assurance.

Sec. 4. Health care quality assurance programs study.

Sec. 5. Reports respecting medically underserved areas and population groups and non-metropolitan areas.

Sec. 6. Health services for Indians and domestic agricultural migratory and seasonal workers.

Sec. 7. Conforming amendments.

HEALTH MAINTENANCE ORGANIZATIONS

SEC. 2. The Public Health Service Act is amended by adding after title XII the following new title: Ante, p. 594.

"TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

"REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

"Sec. 1301. (a) For purposes of this title, the term 'health maintenance organization' means a legal entity which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

Definition.

Basic health
services.

"(b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

"(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary.

"(2) For such payment or payments (hereinafter in this title referred to as 'supplemental health services payments') as the health maintenance organization may require in addition to the basic health services payment, the organization shall provide to each of its members each health service (A) which is included in supplemental health services (as defined in section 1302(2)), (B) for which the required health manpower are available in the area served by the organization, and (C) for the provision of which the member has contracted with the organization. Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system.

"(3) The services of health professionals which are provided as basic health services shall be provided through health professionals who are members of the staff of the health maintenance organization or through a medical group (or groups) or individual practice association (or associations), except that this paragraph shall not apply in the case of (A) health professionals' services which the organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or (B) any basic health service provided a member of the health maintenance organization other than by such a health professional because it was medically necessary that the service be provided to the member before he could have it provided by such a health professional. For purposes of this paragraph, the term 'health professionals' means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

"Health
professionals."

"(4) Basic health services (and supplemental health services in the case of the members who have contracted therefor) shall within the area served by the health maintenance organization be available and accessible to each of its members promptly as appropriate and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic or supplemental health services other than through the organization if it was medically necessary that the services be provided before he could secure them through the organization.

"(c) Each health maintenance organization shall—

"(1) have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary;

"(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may obtain insurance or make other arrangements (A) for the cost of providing to any member basic health services the aggregate value of which exceeds \$5,000 in any year, (B) for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, and (C) for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year;

"(3) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary);

"(4) have an open enrollment period of not less than thirty days at least once during each consecutive twelve-month period during which enrollment period it accepts, up to its capacity, individuals in the order in which they apply for enrollment, except that if the organization demonstrates to the satisfaction of the Secretary that—

"(A) it has enrolled, or will be compelled to enroll, a disproportionate number of individuals who are likely to utilize its services more often than an actuarially determined average (as determined under regulations of the Secretary) and enrollment during an open enrollment period of an additional number of such individuals will jeopardize its economic viability, or

"(B) if it maintained an open enrollment period it would not be able to comply with the requirements of paragraph (3), the Secretary may waive compliance by the organization with the open enrollment requirement of this paragraph for not more than three consecutive twelve-month periods and may provide additional waivers to that organization if it makes the demonstration required by subparagraph (A) or (B);

"(5) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

"(6) be organized in such a manner that assures that (A) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (B) there will be equitable representation on such body of members from medically underserved populations served by the organization;

"(7) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

"(8) have organizational arrangements established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians

and other health professionals of the process followed in the provision of health services;

"(9) provide medical social services for its members and encourage and actively provide for its members health education services, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his own health;

"(10) provide, or make arrangements for, continuing education for its health professional staff; and

"(11) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

"DEFINITIONS

"SEC. 1302. For purposes of this title:

"(1) The term 'basic health services' means—

"(A) physician services (including consultant and referral services by a physician);

"(B) inpatient and outpatient hospital services;

"(C) medically necessary emergency health services;

"(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

"(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

"(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

"(G) home health services; and

"(H) preventive health services (including voluntary family planning services, infertility services, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, or podiatrist, a health maintenance organization may provide such service through a dentist, optometrist, or podiatrist (as the case may be) licensed to provide such service. For purposes of this paragraph, the term 'home health services' means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the health maintenance organization. A health maintenance organization is authorized, in connection with the prescription of drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such service, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

"(2) The term 'supplemental health services' means—

"(A) services of facilities for intermediate and long-term care;

"(B) vision care not included as a basic health service under paragraph (1)(A) or (1)(H);

"(C) dental services not included as a basic health service under paragraph (1)(A) or (1)(H);

"(D) mental health services not included as a basic health service under paragraph (1)(D);

"(E) long-term physical medicine and rehabilitative services (including physical therapy); and

"(F) the provision of prescription drugs prescribed in the course of the provision by the health maintenance organization of a basic health service or a service described in the preceding subparagraphs of this paragraph.

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, or podiatrist, a health maintenance organization may provide such service through an optometrist, dentist, or podiatrist (as the case may be) licensed to provide such service. A health maintenance organization is authorized, in connection with the prescription or provision of prescription drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such services, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

"(3) The term 'member' when used in connection with a health maintenance organization means an individual who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for.

"(4) The term 'medical group' means a partnership, association, or other group—

"(A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

"(B) a majority of the members of which are licensed to practice medicine or osteopathy; and

"(C) the members of which (i) as their principal professional activity and as a group responsibility engage in the coordinated practice of their profession for a health maintenance organization; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) utilize such additional professional personnel, allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the members of the group; and (v) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group.

"(5) The term 'individual practice association' means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optome-

try, or other health profession in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide—

“(A) that such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

“(B) to the extent feasible (i) that such persons shall utilize such additional professional personnel, allied health professions personnel, and other health personnel (as specified in regulations of the Secretary) as are available and appropriate for the effective and efficient delivery of the services of the persons who are parties to the arrangement, (ii) for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff, and (iii) for the arrangement and encouragement of the continuing education of such persons in the field of clinical medicine and related areas.

“(6) The term ‘section 314(a) State health planning agency’ means the agency of a State which administers or supervises the administration of a State’s health planning functions under a State plan approved under section 314(a) (hereinafter in this title referred to as a ‘section 314(a) plan’); and the term ‘section 314(b) areawide health planning agency’ means a public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b) (hereinafter in this title referred to as a ‘section 314(b) plan’).

“(7) The term ‘medically underserved population’ means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each section 314(a) State health planning agency whose section 314(a) plan covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each section 314(b) areawide health planning agency whose section 314(b) plan covers (in whole or in part) such urban or rural area or the area in which such population group resides.

“(8) The term ‘community rating system’ means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. The following differentials in rates of payments may be established under such system:

“(A) Nominal differentials in such rates may be established to reflect the different administrative costs of collecting payments from the following categories of members:

“(i) Individual members (including their families).

“(ii) Small groups of members (as determined under regulations of the Secretary).

“(iii) Large groups of members (as determined under regulations of the Secretary).

“(B) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health

80 Stat. 1181.
42 USC 246.

80 Stat. 863.

5 USC 8901.

benefits program for employees of States, political subdivisions of States, and other public entities.

"(9) The term 'non-metropolitan area' means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.

"GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS

"SEC. 1303. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private entities for projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations.

"(b) An application for a grant or contract under this section shall contain—

"(1) assurances satisfactory to the Secretary that, in conducting surveys or other activities with assistance under a grant or contract under this section, the applicant will (A) cooperate with the section 314(b) areawide health planning agency (if any) whose section 314(b) plan covers (in whole or in part) the area for which the survey or other activity will be conducted, and (B) notify the medical society serving such area of such surveys or other activities; and

80 Stat. 1181;
84 Stat. 1304.
42 USC 246.

"(2) such other information as the Secretary may by regulation prescribe.

"(c) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application or proposal is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.

"(d) (1) Except as provided in paragraph (2), the following limitations apply with respect to grants and contracts made under this section:

Limitations.

"(A) If a project has been assisted with a grant or contract under subsection (a), the Secretary may not make any other grant or enter into any other contract under this section for such project.

"(B) Any project for which a grant is made or contract entered into must be completed within twelve months from the date the grant is made or contract entered into.

"(2) The Secretary may make not more than one additional grant or enter into not more than one additional contract for a project for which a grant has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

"(e) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) shall be determined by the Secretary, except that (1) the amount to be paid by the United States under any single grant or contract for any project may not exceed \$50,000, and (2) the aggregate of the amounts to be paid by the United States for any project under such subsection under grants or contracts, or both, may not exceed the greater of (A) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (B) in the case of a project for a health maintenance organization which will serve a medically underserved

population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants and contracts for such project should be determined by such greater percentage.

"(f) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(g) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(h) Payments under grants and contracts under this section shall be made from appropriations made under section 1309(a).

"(i) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (1) to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations which the Secretary determines may reasonably be expected to have after their development or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (2) the applications for which meet the requirements of this title for approval. Sums set aside in the fiscal year ending June 30, 1974, or June 30, 1975, for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under this section in the succeeding fiscal year for projects other than those described in clause (1) of such sentence.

"GRANTS, CONTRACTS, AND LOAN GUARANTEES FOR PLANNING AND FOR
INITIAL DEVELOPMENT COSTS

"SEC. 1304. (a) The Secretary may—

"(1) make grants to and enter into contracts with public or nonprofit private entities for planning projects for the establishment of health maintenance organizations or for the significant expansion of the membership of, or areas served by, health maintenance organizations; and

"(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to private entities (other than nonprofit private entities) for planning projects for the establishment or expansion of health maintenance organizations to serve medically underserved populations.

Planning projects assisted under this subsection shall include development of plans for the marketing of the services of the health maintenance organization.

"(b)(1) The Secretary may—

"(A) make grants to and enter into contracts with public or nonprofit private entities for projects for the initial development of health maintenance organizations; and

"(B) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to any private entity (other than a nonprofit private entity) for a project for the initial development of a health maintenance organization which will serve a medically underserved population.

"(2) For purposes of this section, the term 'initial development' when used to describe a project for which assistance is authorized by this subsection includes significant expansion of the membership of, or the area served by, a health maintenance organization. Funds under

Post, p.930.

"Initial
development."

grants and contracts under this subsection and under loans guaranteed under this subsection may only be utilized for such purposes as the Secretary may prescribe in regulations. Such purposes may include (A) the implementation of an enrollment campaign for such an organization, (B) the detailed design of and arrangements for the health services to be provided by such an organization, (C) the development of administrative and internal organizational arrangements, including fiscal control and fund accounting procedures, and the development of a capital financing program, (D) the recruitment of personnel for such an organization and the conduct of training activities for such personnel, and (E) the payment of architects' and engineers' fees.

"(3) A grant or contract under this subsection may only be made or entered into for initial development costs in the one-year period beginning on the first day of the first month in which such grant or contract is made or entered into. The number of grants made for any initial development project under this subsection when added to the number of contracts entered into for such project under this subsection may not exceed three. A loan guarantee under this subsection may only be made for a loan (or loans) for such costs incurred in a period not to exceed three years.

"(c)(1) An application for a grant, contract, or loan guarantee under subsection (a) for a planning project shall contain assurances satisfactory to the Secretary that in carrying out the planning project for which the grant, contract, or loan guarantee is sought, the applicant will (A) cooperate with the section 314(b) areawide health planning agency (if any) whose section 314(b) plan covers (in whole or in part) the area proposed to be served by the health maintenance organization for which the planning project will be conducted, and (B) notify the medical society serving such area of the planning project.

80 Stat. 1181;
84 Stat. 1304.
42 USC 246.

"(2) If the Secretary makes a grant or loan guarantee or enters into a contract under subsection (a) for a planning project for a health maintenance organization, he may, within the period in which the planning project must be completed, make a grant or loan guarantee or enter into a contract under subsection (b) for the initial development of that health maintenance organization; but no grant or loan guarantee may be made or contract entered into under subsection (b) for initial development of a health maintenance organization unless the Secretary determines that (A) sufficient planning for its establishment or expansion (as the case may be) has been conducted by the applicant for the grant, contract, or loan guarantee, and (B) the feasibility of establishing and operating, or of expanding, the health maintenance organization has been established by the applicant.

"(d) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.

"(e)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants, loan guarantees, and contracts made under subsection (a) of this section:

Limitations.

"(A) If a planning project has been assisted with grant, loan guarantee, or contract under subsection (a), the Secretary may not make any other planning grant or loan guarantee or enter into any other planning contract for such project under this section.

"(B) Any project for which a grant or loan guarantee is made or contract entered into must be completed within twelve months

from the date the grant or loan guarantee is made or contract entered into.

"(2) The Secretary may not make more than one additional grant or loan guarantee or enter into not more than one additional contract for a planning project for which a grant or loan guarantee has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant, loan guarantee, or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

"(f) (1) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) for a planning project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for a planning project which may be guaranteed under such subsection, shall be determined by the Secretary, except that (A) the amount to be paid by the United States under any single grant or contract, and the amount of principal of any single loan guaranteed under such subsection, may not exceed \$125,000, and (B) the aggregate of the amounts to be paid for any project by the United States under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

"(2) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (b) for an initial development project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for an initial development project which may be guaranteed under such subsection, shall be determined by the Secretary; except that the amounts to be paid by the United States for any initial development project under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the lesser of—

"(A) \$1,000,000, or

"(B) an amount equal to the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

"(3) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.

"(g) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

"(h) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"(i) Payments under grants and contracts under this section shall be made from appropriations under section 1309(a). Post, p.930.

"(j) Loan guarantees under subsection (a) (2) for planning projects may be made through the fiscal year ending June 30, 1976; and loan guarantees under subsection (b) (1) (B) for initial development projects may be made through the fiscal year ending June 30, 1977.

"(k) (1) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (a) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) to plan the establishment or expansion of health maintenance organizations which the Secretary determines may reasonably be expected to have after their establishment or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in the fiscal year ending June 30, 1974, or June 30, 1975, for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (a) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for projects other than those described in clause (A) of such sentence.

"(2) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (b) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) for the initial development of health maintenance organizations which the Secretary determines may reasonably be expected to have after their initial development not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in the fiscal year ending June 30, 1974, or in either of the next two fiscal years for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (b) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for projects other than those described in clause (A) of such sentence.

"LOANS AND LOAN GUARANTEES FOR INITIAL OPERATION COSTS

"SEC. 1305. (a) The Secretary may—

"(1) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their operating costs in the period of the first thirty-six months of their operation exceed their revenues in that period;

"(2) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their operating costs, which the Secretary determines are attributable to significant expansion in their membership or area served and which are incurred in the period of the first thirty-six months of their operation after such expansion, exceed their revenues in that period which the Secretary determines are attributable to such expansion; and

"(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to any private health maintenance organization (other than a private nonprofit health maintenance organization) for the amounts referred to in paragraph (1) or (2), but only if such health maintenance organization will serve a medically underserved population.

Non-Federal
lenders,
guaranteed
payment,
condition.

No loan or loan guarantee may be made under this subsection for the operating costs of a health maintenance organization unless the Secretary determines that the organization has made all reasonable attempts to meet such costs.

Limitations.

"(b) (1) Except as provided in paragraph (2), the principal amount of any loan made or guaranteed under subsection (a) in any fiscal year for a health maintenance organization may not exceed \$1,000,000 and the aggregate amount of principal of loans made or guaranteed, or both, under this section for a health maintenance organization may not exceed \$2,500,000.

"(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made, or with respect to which guarantees have been issued, under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

Post, p. 930.

"(c) Loans under this section shall be made from the fund established under section 1308(e).

"(d) A loan or loan guarantee may be made under this section through the fiscal year ending June 30, 1978.

"(e) Of the sums used for loans under this section in any fiscal year from the loan fund established under section 1308(e), not less than 20 per centum shall be used for loans for projects (1) for the initial operation of health maintenance organizations which the Secretary determines have not less than 66 per centum of their membership drawn from residents of nonmetropolitan areas, and (2) the applications for which meet the requirements of this title for approval.

"APPLICATION REQUIREMENTS

"SEC. 1306. (a) No grant, contract, loan, or loan guarantee may be made under this title unless an application therefor has been submitted to, and approved by, the Secretary.

"(b) The Secretary may not approve an application for a grant, contract, loan, or loan guarantee under this title unless—

Ante, pp. 920,
921.

"(1) in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and in the case of an application for a loan or loan guarantee, such application meets the requirements of section 1308;

"(2) he determines that the applicant making the application would not be able to complete the project or undertaking for which the application is submitted without the assistance applied for;

"(3) the application contains satisfactory specification of the existing or anticipated (A) population group or groups to be served by the proposed or existing health maintenance organization described in the application, (B) membership of such organization, (C) methods, terms, and periods of the enrollment of members of such organization, (D) estimated costs per member of the health and educational services to be provided by such organization and the nature of such costs, (E) sources of professional services for such organization, and organizational arrangements of such organization for providing health and educational services, (F) organizational arrangements of such organization for an ongoing quality assurance program in conformity with the requirements of section 1301(c), (G) sources of prepayment and other forms of payment for the services to be provided by such organization, (H) facilities, and additional capital investments and sources of financing therefor, available to such organization to provide the level and scope of services proposed, (I) administrative, managerial, and financial arrangements and capabilities

Ante, p. 914.

of such organization, (J) role for members in the planning and policymaking for such organization, (K) grievance procedures for members of such organization, and (L) evaluations of the support for and acceptance of such organization by the population to be served, the sources of operating support, and the professional groups to be involved or affected thereby;

"(4) contains or is supported by assurances satisfactory to the Secretary that the applicant making the application will, in accordance with such criteria as the Secretary shall by regulation prescribe, enroll, and maintain an enrollment of the maximum number of members that its available and potential resources (as determined under regulations of the Secretary) will enable it to effectively serve;

"(5) the section 314(b) areawide health planning agency whose section 314(b) plan covers (in whole or in part) the area to be served by the health maintenance organization for which such application is submitted, or if there is no such agency, the section 314(a) State health planning agency whose section 314(a) plan covers (in whole or in part) such area, has, in accordance with regulations of the Secretary under subsection (c) of this section, been provided an opportunity to review the application and to submit to the Secretary for his consideration its recommendations respecting approval of the application or if under applicable State law such an application may not be submitted without the approval of the section 314(b) areawide health planning agency or the section 314(a) State health planning agency, the required approval has been obtained;

"(6) in the case of an application made for a project which previously received a grant, contract, loan, or loan guarantee under this title, such application contains or is supported by assurances satisfactory to the Secretary that the applicant making the application has the financial capability to adequately carry out the purposes of such project and has developed and operated such project in accordance with the requirements of this title and with the plans contained in previous applications for such assistance; and

"(7) the application is submitted in such form and manner, and contains such additional information, as the Secretary shall prescribe in regulations.

An organization making multiple applications for more than one grant, contract, loan, or loan guarantee under this title, simultaneously or over the course of time, shall not be required to submit duplicate or redundant information but shall be required to update the specifications (required by paragraph (3)) respecting the existing or proposed health maintenance organization in such manner and with such frequency as the Secretary may by regulation prescribe.

"(c) The Secretary shall by regulation establish standards and procedures for section 314(b) areawide health planning agencies and section 314(a) State health planning agencies to follow in reviewing and commenting on applications for grants, contracts, loans, and loan guarantees under this title.

"ADMINISTRATION OF ASSISTANCE PROGRAMS

"SEC. 1307. (a) (1) Each recipient of a grant, contract, loan, or loan guarantee under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of the grant, contract, or

80 Stat. 1181;
84 Stat. 1304.
42 USC 246.

Multiple
applications.

Record-
keeping.

loan (directly made or guaranteed), the total cost of the undertaking in connection with which such assistance was given or used, the amount of that portion of the cost of the undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(2) The Secretary, or any of his duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of a grant, contract, loan, or loan guarantee under this title which relate to such assistance.

"(b) Upon expiration of the period for which a grant, contract, loan, or loan guarantee was provided an entity under this title, such entity shall make a full and complete report to the Secretary in such manner as he may by regulation prescribe. Each such report shall contain, among such other matters as the Secretary may by regulation require, descriptions of plans, developments, and operations relating to the matters referred to in section 1306(b)(3).

"(c) If in any fiscal year the funds appropriated under section 1309 are insufficient to fund all applications approved under this title for that fiscal year, the Secretary shall, after applying the applicable priorities under sections 1303 and 1304, give priority to the funding of applications for projects which the Secretary determines are the most likely to be economically viable.

"(d) An entity which provides health services to a defined population on a prepaid basis and which has members who are entitled to insurance benefits under title XVIII of the Social Security Act or to medical assistance under a State plan approved under title XIX of such Act may be considered as a health maintenance organization for purposes of receiving assistance under this title if—

"(1) with respect to its members who are entitled to such insurance benefits or to such medical assistance it (A) provides health services in accordance with section 1301(b), except that (i) it does not furnish to those members the health services (within the basic health services) for which it may not be compensated under such title XVIII or such State plan, and (ii) it does not fix the basic or supplemental health services payment for such members under a community rating system, and (B) is organized and operated in the manner prescribed by section 1301(c), except that it does not assume full financial risk on a prospective basis for the provision to such members of basic or supplemental health services with respect to which it is not required under such title XVIII or such State plan to assume such financial risk; and

"(2) with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).

"(e) In any fiscal year no loan guarantee may be made under this title if the making of such guarantee would cause the cumulative total of the principal of the loans guaranteed under this title in such fiscal year to exceed the amount of grant and contract funds obligated under this title in such fiscal year; except that this subsection shall not apply if the amount of grant and contract funds obligated under this title in such fiscal year equals the sums appropriated under section 1309 for grants and contracts for such fiscal year.

"GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

"SEC. 1308. (a) (1) The Secretary may not approve an application for a loan guarantee under this title unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the finan-

Report to
Secretary of
H.E.W.

Ante, p. 925.

Post, p. 930.

79 Stat. 291;
86 Stat. 1370,
42 USC 1395,
42 USC 1396.

cial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for similar loans and the risks assumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this title.

"(2) (A) The United States shall be entitled to recover from the applicant for a loan guarantee under this title the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

"(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this title (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

"(C) Any loan guarantee made by the Secretary under this title shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

"(D) Guarantees of loans under this title shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

"(b) (1) The Secretary may not approve an application for a loan under this title unless—

Application
requirements.

"(A) the Secretary is reasonably satisfied that the applicant therefor will be able to make payments of principal and interest thereon when due, and

"(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

"(2) Any loan made under this title shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this title, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

"(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reason of the failure of a borrower to make payments of principal of and interest on a loan made under this title, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

Right of
recovery,
waiver.

"(c) (1) The Secretary may from time to time, but with due regard to the financial interests of the United States, sell loans made by him under this title.

Sale of loans.

"(2) The Secretary may agree, prior to his sale of any such loan, to guarantee to the purchaser (and any successor in interest of the purchaser) compliance by the borrower with the terms and conditions of such loan. Any such agreement shall contain such terms and conditions as the Secretary considers necessary to protect the financial interests of the United States or as otherwise appropriate. Any such agreement may (A) provide that the Secretary shall act as agent of any such purchaser for the purpose of collecting from the borrower to which such loan was made and paying over to such purchaser, any payments of principal and interest payable by such organization under such loan; and (B) provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement. The full faith and credit of the United States is pledged to the payment of all amounts which may be required to be paid under any guarantee under this paragraph.

"(3) After any loan under this title to a public health maintenance organization has been sold and guaranteed under this subsection, interest paid on such loan which is received by the purchaser thereof (or his successor in interest) shall be included in the gross income of the purchaser of the loan (or his successor in interest) for the purpose of chapter 1 of the Internal Revenue Code of 1954.

"(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the loan fund established under subsection (e).

"(d) (1) There is established in the Treasury a loan guarantee fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to discharge his responsibilities under loan guarantees issued by him under this title. There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. To the extent authorized in appropriation Acts, there shall also be deposited in the fund amounts received by the Secretary in connection with loan guarantees under this title and other property or assets derived by him from his operations respecting such loan guarantees, including any money derived from the sale of assets.

"(2) If at any time the sums in the funds are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him under this title, he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund

68A Stat. 3.
26 USC 1
et seq.

Loan guarantee
fund.
Establishment.

40 Stat. 288.
31 USC 774.

and redemption of such notes and obligations shall be made by the Secretary from the fund.

"(e) There is established in the Treasury a loan fund (hereinafter in this subsection referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to make loans under this title. There shall also be deposited in the fund amounts received by the Secretary as interest payments and repayment of principal on loans made under this title and other property or assets derived by him from his operations respecting such loans, from the sale of loans under subsection (c) of this section, or from the sale of assets.

Loan fund.
Establishment.

"AUTHORIZATIONS OF APPROPRIATIONS

"SEC. 1309. (a) For the purpose of making payments under grants and contracts under sections 1303, 1304(a), and 1304(b), there are authorized to be appropriated \$25,000,000 for the fiscal year ending June 30, 1974, \$55,000,000 for the fiscal year ending June 30, 1975, and \$85,000,000 for the fiscal year ending June 30, 1976; and for the purpose of making payments under grants and contracts under section 1304(b) for the fiscal year ending June 30, 1977, there is authorized to be appropriated \$85,000,000.

"(b) There is authorized to be appropriated to the loan fund established under section 1308(e) \$75,000,000 in the aggregate for the fiscal years ending June 30, 1974, and June 30, 1975.

"EMPLOYEES' HEALTH BENEFITS PLANS

"SEC. 1310. (a) Each employer which is required during any calendar quarter to pay its employees the minimum wage specified by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay his employees such wage but for section 13(a) of such Act), and which during such calendar quarter employed an average number of employees of not less than twenty-five, shall, in accordance with regulations which the Secretary shall prescribe, include in any health benefits plan offered to its employees in the calendar year beginning after such calendar quarter the option of membership in qualified health maintenance organizations which are engaged in the provision of basic and supplemental health services in the areas in which such employees reside.

52 Stat. 1062;
77 Stat. 56;
80 Stat. 838.
29 USC 201.
75 Stat. 71;
80 Stat. 833;
86 Stat. 375.
29 USC 213.

"(b) If there is more than one qualified health maintenance organization which is engaged in the provision of basic and supplemental health services in the area in which the employees of an employer subject to subsection (a) reside and if—

"(1) one or more of such organizations provides basic health services through professionals who are members of the staff of the organization or a medical group (or groups), and

"(2) one or more of such organizations provides such services through an individual practice association (or associations), then of the qualified health maintenance organizations included in a health benefits plan of such employer pursuant to subsection (a) at least one shall be an organization which provides basic health services as described in clause (1) and at least one shall be an organization which provides basic health services as described in clause (2).

"(c) No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees. Failure of any employer to

52 Stat. 1068;
63 Stat. 919.
29 USC 215.
"Qualified
health
maintenance
organization."

comply with the requirements of subsection (a) shall be considered a willful violation of section 15 of the Fair Labor Standards Act of 1938.

"(d) For purposes of this section, the term 'qualified health maintenance organization' means (1) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 1301(b) and that it is organized and operated in the manner prescribed by section 1301(c), and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 1301(b) and will be organized and operated in the manner prescribed by section 1301(c).

"RESTRICTIVE STATE LAWS AND PRACTICES

"SEC. 1311. (a) In the case of any entity—

"(1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise—

"(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

"(B) requires that physicians constitute all or a percentage of its governing body,

"(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, or

"(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, and

"(2) for which a grant, contract, loan, or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section 1310 (relating to employees' health benefits plans),

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 1301.

"(b) No State may establish or enforce any law which prevents a health maintenance organization for which a grant, contract, loan, or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section 1310 (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

"CONTINUED REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

"SEC. 1312. (a) If the Secretary determines that an entity which received a grant, contract, loan, or loan guarantee under this title as a health maintenance organization or which was included in a health benefits plan offered to employees pursuant to section 1310—

"(1) fails to provide basic and supplemental services to its members,

"(2) fails to provide such services in the manner prescribed by section 1301(b), or

"(3) is not organized or operated in the manner prescribed by section 1301(c),

the Secretary may, in addition to any other remedies available to him, bring a civil action in the United States district court for the district in which such entity is located to enforce its compliance with any assurances it furnished him respecting the provision of basic and supplemental health services or its organization or operation, as the case may be, which assurances were made under section 1310 or when application was made under this title for a grant, contract, loan, or loan guarantee.

"(b) The Secretary, through the Assistant Secretary for Health, shall administer subsection (a) in the Office of the Assistant Secretary for Health.

"LIMITATION ON SOURCE OF FUNDING FOR HEALTH MAINTENANCE
ORGANIZATIONS

"SEC. 1313. No funds appropriated under any provision of this Act other than this title may be used—

"(1) for grants or contracts for surveys or other activities to determine the feasibility of developing or expanding health maintenance organizations or other entities which provide, directly or indirectly, health services to a defined population on a prepaid basis;

"(2) for grants or contracts, or for payments under loan guarantees, for planning projects for the establishment or expansion of such organizations or entities;

"(3) for grants or contracts, or for payments under loan guarantees, for projects for the initial development or expansion of such organizations or entities; or

"(4) for loans, or for payments under loan guarantees, to assist in meeting the costs of the initial operation after establishment or expansion of such organizations or entities.

"PROGRAM EVALUATION

"SEC. 1314. (a) The Comptroller General shall evaluate the operations of at least fifty of the health maintenance organizations for which assistance was provided under section 1303, 1304, or 1305. The period of operation of such health maintenance organizations which shall be evaluated under this subsection shall be not less than thirty-six months. The Comptroller General shall report to the Congress the results of the evaluation not later than ninety days after at least fifty of such health maintenance organizations have been in operation for at least thirty-six months. Such report shall contain findings—

Report to
Congress.

"(1) with respect to the ability of the organizations evaluated to operate on a fiscally sound basis without continued Federal financial assistance,

"(2) with respect to the ability of such organizations to meet the requirements of section 1301(c) respecting their organization and operation,

"(3) with respect to the ability of such organizations to provide basic and supplemental health services in the manner prescribed by section 1301(b),

"(4) with respect to the ability of such organizations to include indigent and high-risk individuals in their membership, and

"(5) with respect to the ability of such organizations to provide services to medically underserved populations.

87 STAT. 933

Study.

"(b) The Comptroller General shall also conduct a study of the economic effects on employers resulting from their compliance with the requirements of section 1310. The Comptroller General shall report to the Congress the results of such study not later than thirty-six months after the date of the enactment of this title.

Report to Congress.

"(c) The Comptroller General shall evaluate (1) the operations of distinct categories of health maintenance organizations in comparison with each other, (2) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and (3) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public. The Comptroller General shall report to the Congress the results of such evaluation not later than thirty-six months after the date of the enactment of this title.

"ANNUAL REPORT

Review, report to Congress.

"SEC. 1315. (a) The Secretary shall periodically review the programs of assistance authorized by this title and make an annual report to the Congress of a summary of the activities under each program. The Secretary shall include in such summary—

"(1) a summary of each grant, contract, loan, or loan guarantee made under this title in the period covered by the report and a list of the health maintenance organizations which during such period became qualified health maintenance organizations for purposes of section 1310;

"(2) the statistics and other information reported in such period to the Secretary in accordance with section 1301(c) (11);

"(3) findings with respect to the ability of the health maintenance organizations assisted under this title—

"(A) to operate on a fiscally sound basis without continued Federal financial assistance,

"(B) to meet the requirements of section 1301(c) respecting their organization and operation,

"(C) to provide basic and supplemental health services in the manner prescribed by section 1301(b),

"(D) to include indigent and high-risk individuals in their membership, and

"(E) to provide services to medically underserved populations; and

"(4) findings with respect to—

"(A) the operation of distinct categories of health maintenance organizations in comparison with each other,

"(B) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and

"(C) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public.

Review.

"(b) The Office of Management and Budget may review the Secretary's report under subsection (a) before its submission to the Congress, but the Office may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such report."

Comments, submission to Congress.

QUALITY ASSURANCE

58 Stat. 691;
85 Stat. 65.
42 USC 241.

SEC. 3. Title III of the Public Health Service Act is amended by adding at the end thereof the following new part:

"PART K—QUALITY ASSURANCE

"QUALITY ASSURANCE

"SEC. 399c. (a) (1) The Secretary, through the Assistant Secretary for Health, shall conduct research and evaluation programs respecting the effectiveness, administration, and enforcement of quality assurance programs. Such research and evaluation programs shall be carried out in cooperation with the entity within the Department which administers the programs of assistance under section 304.

Research and
evaluation
programs.

"(2) For the purpose of carrying out paragraph (1), there are authorized to be appropriated \$4,000,000 for the fiscal year ending June 30, 1974, \$8,000,000 for the fiscal year ending June 30, 1975, \$9,000,000 for the fiscal year ending June 30, 1976, \$9,000,000 for the fiscal year ending June 30, 1977, and \$10,000,000 for the fiscal year ending June 30, 1978.

81 Stat. 534.
42 USC 242b.
Appropriation.

"(b) The Secretary shall make an annual report to the Congress and the President on (1) the quality of health care in the United States, (2) the operation of quality assurance programs, and (3) advances made through research and evaluation of the effectiveness, administration, and enforcement of quality assurance programs. The first annual report under this subsection shall be made with respect to calendar year 1974 and shall be submitted not later than March 1, 1975. The Office of Management and Budget may review the Secretary's report under this subsection before its submission to the Congress, but the Office may not revise the report or delay its submission to the Congress, and it may submit to the Secretary and the Congress its comments (and those of other departments and agencies of the Government) with respect to such report."

Annual report
to President
and Congress.

HEALTH CARE QUALITY ASSURANCE PROGRAMS STUDY

SEC. 4. (a) The Secretary of Health, Education, and Welfare shall contract, in accordance with subsection (b), for the conduct of a study to—

(1) analyze past and present mechanisms (both required by law and voluntary) to assure the quality of health care, identify the strengths and weaknesses of current major prototypes of health care quality assurance systems, and identify on a comparable basis the costs of such prototypes;

(2) provide a set of basic principles to be followed by any effective health care quality assurance system, including principles affecting the scope of the system, methods for assessing care, data requirements, specifications for the development of criteria and standards which relate to desired outcomes of care, and means for assessing the responsiveness of such care to the needs and perceptions of the consumers of such care;

(3) provide an assessment of programs for improving the performance of health practitioners and institutions in providing high-quality health care, including a study of the effectiveness of sanctions and educational programs;

(4) define the specific needs for a program of research and evaluation in health care quality assurance methods, including the design of prospective evaluations protocols for health care quality assurance systems; and

(5) provide methods for assessing the quality of health care from the point of view of consumers of such care.

(b) The Secretary shall contract for the conduct of the study required by subsection (a) with a nonprofit private organization which—

Contract with
private organi-
zation.

87 STAT. 935

(1) has a national reputation for objectivity in the conduct of studies for the Federal Government;

(2) has the capacity to readily marshal the widest possible range of expertise and advice relevant to the conduct of such study;

(3) has a membership and competent staff which have backgrounds in government, the health sciences, and the social sciences;

(4) has a history of interest and activity in health policy issues related to such study; and

(5) has extensive existing contracts with interested public and private agencies and organizations.

The Secretary shall enter into such contract within 90 days of the date of the enactment of the first Act making an appropriation under subsection (d).

Reports to congressional committees.

(c) An interim report providing a plan for the study required by subsection (a) shall be submitted by the organization conducting the study to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate by June 30, 1974; and a final report giving the results of the study and providing specifications for an effective quality assurance system shall be submitted by such organization to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate by January 31, 1976.

Appropriation.

(d) There is authorized to be appropriated \$10,000,000, which shall be available without fiscal year limitation, for the conduct of the study required by subsection (a).

REPORTS RESPECTING MEDICALLY UNDERSERVED AREAS AND POPULATION GROUPS AND NON-METROPOLITAN AREAS

Reports to Congress.

SEC. 5. Within three months of the date of the enactment of this Act, the Secretary of Health, Education, and Welfare shall report to the Congress the criteria used by him in the designation of medically underserved areas and population groups for the purposes of section 1302(7) of the Public Health Service Act. Within one year of such date, the Secretary shall report to the Congress (1) the areas and population groups designated by him under such section 1302(7) as having a shortage of personal health services, (2) the comments (if any) submitted by State and areawide comprehensive health planning agencies under such section with respect to any such designation, and (3) the areas which meet the definitional standards under section 1302(9) of such Act for non-metropolitan areas. The Office of Management and Budget may review the Secretary's report under this section before its submission to the Congress, but the Office may not revise the report or delay its submission beyond the date prescribed for its submission, and it may submit to Congress its comments (and those of other departments and agencies of the Government) respecting such report.

Ante, p. 917.

Review.

Comments, submittal to Congress.

HEALTH SERVICES FOR INDIANS AND DOMESTIC AGRICULTURAL MIGRATORY AND SEASONAL WORKERS

68 Stat. 674.

SEC. 6. (a) The first section of the Act of August 5, 1954 (42 U.S.C. 2001), is amended by inserting "(a)" after "That" and by adding at the end thereof the following new subsection:

"(b) In carrying out his functions, responsibilities, authorities, and duties under this Act, the Secretary is authorized, with the consent of the Indian people served, to contract with private or other non-

December 29, 1973

- 23 -

Pub. Law 93-222

87 STAT. 936

Federal health agencies or organizations for the provision of health services to such people on a fee-for-service basis or on a prepayment or other similar basis.”

(b) The Secretary of Health, Education, and Welfare, in connection with existing authority (except section 310 of the Public Health Service Act) for the provision of health services to domestic agricultural migratory workers, to persons who perform seasonal agricultural services similar to the services performed by such workers, and to the families of such workers and persons, is authorized to arrange for the provision of health services to such workers and persons and their families through health maintenance organizations. In carrying out this subsection the Secretary may only use sums appropriated after the date of the enactment of this Act.

76 Stat. 592.
42 USC 242h.

CONFORMING AMENDMENTS

SEC. 7. (a) Section 1 of the Public Health Service Act is amended to read as follows:

58 Stat. 682;
86 Stat. 137.
42 USC 201 note.

“SHORT TITLE

“SECTION 1. This Act may be cited as the ‘Public Health Service Act.’”

(b) Title XIII of the Act of July 1, 1944 (58 Stat. 682) (as so designated by section 2(b) of the Emergency Medical Services Systems Act of 1973 (Public Law 93-154)) is repealed.

Repeal.
Ante, p. 604.

(c) Section 306(g) of the Federal National Mortgage Association Act (12 U.S.C. 1721(g)) is amended by inserting “, or which are guaranteed under title XIII of the Public Health Service Act” after “chapter 37 of title 38, United States Code”.

82 Stat. 542.
38 USC 1801.

Approved December 29, 1973.

LEGISLATIVE HISTORY:

HOUSE REPORTS: No. 93-451 accompanying H. R. 7974 (Comm. on Interstate and Foreign Commerce) and No. 93-714 (Comm. of Conference).

SENATE REPORTS: No. 93-129 (Comm. on Labor and Public Welfare) and No. 93-621 (Comm. of Conference).

CONGRESSIONAL RECORD, Vol. 119 (1973):

May 14, 15, considered and passed Senate.

Sept. 12, considered and passed House, amended, in lieu of H. R. 7974.

Dec. 18, House agreed to conference report.

Dec. 19, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 10, No. 1 (1974):

Dec. 29, 1973, Presidential statement.

Senator KENNEDY. Thank you, Senator Schweiker.

Our first witness this morning is Mr. James D. Martin, Deputy Director for Manpower and Welfare Division, of the General Accounting Office.

STATEMENT OF JAMES D. MARTIN, DEPUTY DIRECTOR, MANPOWER AND WELFARE DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS J. SCHULZ, HMO PROJECT MANAGER, AND DAYNA KINNARD, COUNSEL

Mr. MARTIN. Mr. Chairman and members of the subcommittee, I am pleased to appear here today to discuss our current review on the implementation of the Health Maintenance Organization—HMO—Act of 1973. The review was initiated to provide Congress with information on: (1) Department of Health, Education, and Welfare management actions needed to accomplish congressional objectives in an efficient and effective manner, and (2) legislative changes, if any, needed to accomplish stated objectives for HMO development.

My statement will provide information on the implementation of the HMO program by HEW and our views on (1) the HMO Act amendments proposed by S. 1926, and (2) other changes to the HMO Act which the subcommittee may wish to consider.

The Health Maintenance Organization Act of 1973 (87 Stat. 914), approved December 29, 1973, amended the Public Health Service Act to provide a trial Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMO's.

The act spells out in considerable detail the definition of and the requirements for an HMO. Among other things, the act specifies the basic and supplemental health services to be provided the HMO membership, the basis for fixing the rate of prepayment, the requirement that HMO's have open enrollment periods for individual members without restrictions—such as preexisting medical conditions—and the organizational structure of an HMO.

The act authorizes a 5-year demonstration program designed to promote the development of new—and the expansion of existing—HMO's, by:

Providing financial assistance through grants, contracts and loans.

Providing a market for HMO's by requiring certain employers to include in any health benefits plan offered to employees the option of membership in an HMO that the Secretary of HEW has "qualified" to be in compliance with the requirements of the HMO Act.

Removing restrictive State laws and practices which could serve to hinder the development and operation of a qualified HMO.

As of June 30, 1975, HEW had received 375 grant applications for about \$59 million, and had awarded 180 grants totaling about \$22.5 million to 157 projects.

As of November 14, 1975, HEW had received 54 fiscal year 1976 grant applications for about \$10.6 million and had awarded about \$3 million to 8 projects. Thirty-three of the 54 were new applicants which had not been previously funded under the act, and processing of the new applications is not scheduled to be completed until January 1976.

By November 14, 1975, HEW had also "qualified" seven HMO's, but such qualification for four of the seven was only for the purpose of eligibility for HMO loans and initial development grants for expansion purposes. The qualification of one additional HMO is awaiting the final commitment of a Federal HMO loan. As of November 14, 1975, five of the seven had received HMO loans or loan commitments which totaled about \$7.8 million.

Slow progress in implementation of the HMO program is evident, in that HEW had not used over \$17.5 million of the \$40 million in grant funds which were available for fiscal years 1974 and 1975. Further, the administration has requested only \$15 million of the \$85 million currently authorized for grants in fiscal year 1976. We have recently become aware that HEW has under consideration plans to allow to expire a number of HMO grant projects funded in fiscal year 1975 primarily because the current and projected HMO grant budget cannot support continued funding.

Also, as of this date, final regulations have not been published in the Federal Register for implementing a critical section of the act dealing with the form of HEW's continued regulation of HMO's assisted by or qualified under the act. Final regulations implementing the funding criteria for the HMO grant and loan programs were published about 10 months after enactment of the law, and the final regulations outlining the process of obtaining qualification of an HMO were published about 19 months after enactment. Final regulations implementing the "dual choice" offering of HMO's by employers in health benefits plans were published on October 28, 1975—approximately 22 months after the passage of the act.

As part of our review, we sent a questionnaire survey to about 800 entities who had been identified by HEW's regional offices as those—nationwide—likely to seek the financial assistance under the act. Five hundred and sixty-two or about 73 percent of the 768 locatable entities responded.

This survey, along with other recently published studies, indicates that there are entities who wish to participate in the Federal HMO program but, for various reasons, have chosen not to. These reasons include the lack of final regulations and basic disagreements with certain sections of the act, and with certain actions of HEW. We will specifically discuss some of the information provided in response to our questionnaire later in our statement.

During our review of the implementation of the HMO Act, we have observed that no single organizational unit within HEW is responsible for the entire HMO program. The HMO program has been decentralized to 10 regional offices and functionalized within various headquarters offices, but HEW has not developed a system to coordinate program activities or to account for the utilization of staff resources.

The primary responsibility for administering the grant, loan, and technical assistance programs for HMO's rests with the Office of HMO's, which was, until November 7, 1975, part of the Bureau of Community Health Services of the Health Services Administration—HSA. The Office of HMO's was one of six program offices within the Bureau of Community Health Services, which also has five functional divisions and two administrative support offices for such activities as policy development, monitoring and analysis, and health services fi-

nancing. These divisions and offices are staffed from the resources appropriated to the program.

Bureau of Community Health Services officials maintained that the HMO program was obtaining staff years of effort equivalent to the number of staff positions authorized for the program, but we found that the Bureau had no formal system to account for utilization of its authorized staff resources other than assuming that if a particular task was accomplished on time, all staff resources were used. Thus, while the Bureau may have estimated that it required 1,200 staff days to accomplish a task, that is, issue regulations by a certain date, it had no ongoing management information system to determine whether it used 200, 1,200, or 2,000 staff days, nor could it determine the amount of time each office or division staff worked on the task.

During the July hearings on the House of Representatives' version of the HMO Amendments of 1975, concern was expressed that some of the HMO program's difficulties were partly attributable to the way the program was being administered by the Department. Section 14 of the House bill, H.R. 9019, approved by the House on November 7, 1975, would require HEW to administer the HMO program, excepting the qualification and regulation activities, through a single identifiable unit of the Department.

In response to the concerns expressed by the House, the Acting Assistant Secretary for Administration and Management, HEW, approved on November 7, 1975, a proposal to consolidate the HMO program staff positions then functionally distributed in the Bureau of Community Health Services as one office within another HSA Bureau—the Bureau of Medical Services.

The 10 regional offices have responsibilities which include the monitoring of and providing technical assistance to the HMO grant and loan projects. The regional health administrators report directly to the Office of the Assistant Secretary for Health and are not accountable to the Administrator of HSA or other agency heads.

At the time of our regional review in the spring of this year, we found that the Bureau of Community Health Services had no management information system to trace or account for regional staff resources. Some regions did fill out monthly reports in which they estimate how many days were spent on such activities as monitoring, technical assistance, and grant application review, to help determine if they are meeting work plan objectives. All regions are scheduled to prepare such reports in fiscal year 1976.

The qualification and regulation of HMO's are the responsibility of an HSA office separate from the Bureau and the regional offices. This Office of HMO Qualification and Compliances was officially established in June 1975 and is presently hiring staff to reach its authorized fiscal year 1976 level of 15 positions.

Information provided by our review indicates that HEW does not have the number and type of personnel needed to implement the program. This has resulted in the lack of uniformity among the HEW regional offices in carrying out their responsibilities for HMO grant award review, grant monitoring and the provision of technical assistance to HMO grantees. Thus, the access to a national program of HMO development varies from region to region. We were told of instances where a regional office has actively discouraged the submission of

grantee applications due to a lack of staff to process the applications, and where regional offices were unable to make staff resources available for assistance to potential grant applicants. We should note that discouragement of additional grant activity when there is a lack of staff to adequately administer the Federal program and funds may be a prudent action.

In February of 1974, the Administrator of HSA allocated 50 positions for the HMO program to the regional offices. In September 1975, 46—33 professional and 13 clerical—regional positions were filled. This does not mean, however, that 46 people are working full time on the HMO program. While work plans prepared by the regional health administrators commit a total of 50 staff year equivalents to the HMO program, they do not have to identify to HSA the specific individuals working on HMO's. Our review in the spring of 1975 found, however, that individuals filling regional HMO professional positions were working on HMO's at least the majority of their time, if not full time. The individuals in the HMO clerical positions were not necessarily working on HMO's, even part time, since there was a shortage of clerical-secretarial help in some of the regions and such employees were used wherever needed.

While some regional offices are not providing technical assistance to grantees partly because of a shortage of staff, the problem is not only with quantity but also with staff expertise. When the Administrator of HSA allocated 50 positions to the regional offices, he emphasized the need for specialists in the areas of marketing, actuarial analysis, and financial management, who also have a knowledge of prepaid health plans. Few regions have filled their positions with the personnel that have this expertise. Most of the regional staff are generalists who have expertise in health care delivery systems, hospital administration, disease control or Federal grants management, and usually a general knowledge of prepaid health care. Several regional officials told us that individuals with the desired expertise will not work for the Federal Government at the grade levels and salary offered.

The lack of an adequate number of staff with expertise is also a problem in the headquarters operation. For example, one contributing factor to the delay in issuing final regulations to implement the HMO program is the lack of legal staff. Since January 1974, there has been only one staff attorney assigned, part time, 70 to 80 percent, to the HMO program. The Assistant General Counsel for Health considers this staffing level too low, considering the number of regulations and related legal opinions required by the HMO program.

As of November 14, 1975, the Office of HMO Qualification and Compliance had three professionals and four clerical-secretarial staff members; only three of the clerical-secretarial staff were hired as part of officially authorized 15 positions, the others being on loan from the Bureaus or assigned directly to the Administrator of HSA. The Office at that time had 7 HMO qualification applications in process, 10 applications awaiting processing and 4 HMO's qualified previous to the issuance of final "dual choice" regulations to reprocess. We were informed that the processing of an application takes an average of 84 staff days, and even if the 15 positions were filled, any additional applications which came this calendar year could not begin processing until early 1976.

The HMO Act of 1973 recognized the need for community and professional acceptance of HMO's as a necessary prerequisite for successful development of the concept, by requiring review and comment by Comprehensive Health Planning agencies—CPH's—on grant and loan applications and medical society notification of certain grant applications.

Final regulations published in October 1974, set out specific aspects of a grant or loan application that need CHP review and comment. We were informed at all of the regional offices that the CHP comments were general in nature, were not submitted within the prescribed 60 days in several instances, and did not comply with the regulations. The HMO personnel stated that several CHP's did not have the staff resources to adequately review HMO applications. Regional officials responsible for CHP's generally confirmed this observation.

We further found that the CHP comments that were received by some Regions had little impact on the grant review process and there was significant variation in the regional office use of the CHP comments. For example, some regions virtually ignored the CHP role and completed their grant review process before the CHP comments were due. On the other hand, some regions not only included the CHP comments in the formal grant review process, but met with CHP officials during the preaward site visits.

In our questionnaire, we asked both those who did and did not apply for financial assistance under the act what degree of support or opposition to their application—or their intent to apply—came from the CHP's and medical societies. The majority of respondents who did contact the CHP's and medical societies, indicated that they received support or at least did not receive opposition. However, 41 of the 225 respondents to the question said that they had encountered opposition from the local medical societies. Of the 41, 15, or about 37 percent, were in region VI—Dallas, 8, or about 20 percent, were in region V—Chicago, 5, or about 12 percent, were in region IX—San Francisco, 4, or about 10 percent, in region IV—Atlanta, and the balance were scattered among 4 other regions. No opposition was reported by respondents in regions III—Philadelphia, and VIII, Denver.

The HMO Act requires extensive program evaluation by HEW and GAO. Section 1315 of the act requires the Secretary of HEW to make an annual report to the Congress on HMO activities which includes:

A summary of grant and loan awards.

Findings with respect to the ability of HMO's assisted under the act to: (1) Operate on a fiscally sound basis without continued Federal assistance; (2) meet the organization and operation requirements of section 1301; (3) to include indigent and high-risk individuals in their membership; and (4) to provide services to medically underserved populations.

Also, HEW is to report on findings with respect to:

The operation of distinct categories of HMO's in comparison with each other.

HMO's as a group in comparison with alternative forms of health care delivery.

The impact of HMO's on the health of the public.

Section 1314 of the act places similar evaluation requirements on GAO with 3 exceptions: (1) We do not have to make an annual

report to the Congress on these areas; (2) in addition, we must evaluate 50 HMO's financially assisted under the act after they have been delivering services for at least 36 months; and (3) we must also conduct a study of the economic effects on employers resulting from their compliance with the requirements of section 1310—the dual choice provisions of the act.

This latter study, and GAO's evaluation of the operations of distinct categories of HMO's—HMO's in comparison with alternative forms of health care delivery and the impact of the HMO's on the health care of the public—are due in December 1976.

To avoid placing duplicate information demands on HMO's we would like to utilize the data that HEW obtains from the HMO's to meet our evaluation requirements.

HEW has developed data reporting requirements which will not, in our opinion, provide sufficient information for the evaluations required by section 1315. HEW will rely on special studies to meet its evaluation requirements. In fiscal year 1975, there were three special studies prepared, at a total cost of about \$93,000, which analyzed potential and existing operational prepaid plans with regard to: (1) The barriers to participation in the Federal programs authorized by the HMO Act; (2) economic viability of an HMO serving a rural population; and (3) cost competitiveness of HMO's to other prepaid plans and group health insurers in selected metropolitan areas.

The responsibility for HEW's evaluations has been dispersed to two separate operating groups within HSA. Since the passage of the act, one of these groups has undergone significant turnover in staff while the other had made several reassignments of the evaluation responsibility within the group. In September 1975, the two HSA groups had started to initiate working agreements on how to establish priorities for the evaluations. However, by November 14, 1975, funding for the proposed fiscal year 1976 HMO special studies had not been approved. The proposed HMO evaluation effort is three studies with a total budget of about \$65,000.

S. 1926 includes proposed amendments—sections 2 and 5—which would reduce the scope of basic health services to be provided by HMO's and would allow HMO's, at their option, to provide certain supplementary health care services. Certain services now required to be delivered by HMO's would be considered supplementary health services, which, if the amendments are enacted as proposed, would not have to be made available by HMO's.

Our questionnaire asked if the basic health service requirements in the act would make HMO's noncompetitive with other types of health benefit plans. Of the 306 who responded on this matter, 170, or 56 percent stated that the comprehensive package of basic and supplementary health services required by the act would make HMO's noncompetitive. Further analyses of the responses to this question showed that of the 194 respondents who indicated they were delivering health services, there were 30 prepaid providers, 114 fee-for-service providers, and 50 combination—prepaid and fee-for-service—providers. Some 47 percent of the prepaid providers, 50 percent of the fee-for-service providers, and 68 percent of the combination type providers indicated that the required benefit package made HMO's noncompetitive.

Of the basic services currently required by the act, treatment and services for alcohol or drug abuse and preventive dental care for children, were identified by about 48 and 40 percent, respectively, of 301 respondents to these points as those which they agreed made HMO's too expensive and noncompetitive.

Section 4 of the proposed amendments would delete the "open enrollment" requirement of the act. Of the 308 respondents to our questionnaire on this matter, 142—or 46 percent—stated that they agreed that requiring "open enrollment" periods for HMO's would make them noncompetitive. Some 71, or 23 percent, disagreed, and 95, or 31 percent, had no firm opinion or had no basis to respond. Of the 30 respondents who were delivering health services on a prepaid basis 60 percent indicated that the "open enrollment" requirement would make HMO's noncompetitive. The HMO Act currently allows the Secretary of HEW to waive the "open enrollment" requirement and regulations issued October 18, 1974, outline the waiver process. As of November 14, 1975, seven requests for a waiver had been submitted, but final action had not been taken because HEW criteria to review the circumstances justifying a waiver have not been prepared.

The HMO Act requires HMO's to establish premiums based on a community rate rather than on an experience rate. This means that HMO's can not establish prepayment rates based on health utilization experience, age, or sex differences among groups to whom they market. HMO's must establish one community rate which applies to all members. One of the purposes for community rating is to spread equally among all HMO members the financial costs for comparable coverage.

Of the 307 respondents to the "community rating" question on our questionnaire, 135, or 44 percent, stated that community rating requirements make HMO's noncompetitive; 79, or 26 percent disagreed, and 93, or 30 percent, had no opinion or basis to respond.

Section 6 of S. 1926 proposes to delay the imposition of the community rating requirement until 5 years after an HMO becomes "qualified." We have no information which indicates that such a delay will contribute to the eventual success of an HMO. Additionally, the full impact of community rating under the act is unclear, since program guidelines containing the HEW interpretation of how community rating should translate into a premium rate structure have yet to be published.

S. 1926 includes proposed amendments—sections 8 and 9, which would expand the loan guarantee program by eliminating the requirement that for-profit HMO's must serve medically underserved areas to be eligible for the loan guarantee program and by making the loan guarantee program available for nonprofit HMO's.

Our review disclosed that HEW has not developed uniform policies and procedures for administering and monitoring the loan and the loan guarantee program—loans which have been made were handled on a case-by-case basis, and HEW has not yet used the loan guarantee authority. HEW also does not have the number of experienced personnel, especially in the field, needed to effectively monitor the loan and the loan guarantee program.

If additional activity results from enactment of the amendments, then HEW will definitely need additional personnel as well as uniform operating policies and procedures.

Section 1310 of the HMO Act says that every employer with at least 25 employees, who is required to pay the minimum wage and who offers health benefits to its employees, is to offer, as a choice, the option of joining a qualified HMO. This is the so-called dual choice provision. Section 10 of S. 1926 would lessen the administrative burden placed on employers by providing that an employer does not have to consider an HMO under the dual choice provisions unless 25 or more of his employees reside in the HMO's service area. We favor this amendment, but question whether the Federal Government should be excluded as an "employer" as proposed by another amendment to section 1310. (section 10(f) of S. 1926.)

It appears to us that the exclusion of the Federal Government from the dual choice provisions denies a substantial market to developing HMO's.

H.R. 9019 addresses our concerns while retaining the exclusion of the Federal Government from the dual choice provisions by revising the United States Code (sections 5 U.S.C. 8092, 8903(4)) which governs the Federal Employees' health benefits program. Section 9(b) of H.R. 1919 would require the Civil Service Commission to contract with an HEW qualified HMO that also meets Civil Service Commission requirements.

While we can support the basic thrust of the proposed subsections 10(2) and 10(3) of S. 1926 which would delete the criminal sanctions made applicable by section 1310(c) in favor of the imposition of a civil penalty imposed by the Secretary of HEW, we feel that this proposed amendment should refer to the Administrative Procedure Act (5 U.S.C., § 554-557 and 706) for administrative and judicial procedures to be followed and to better protect the due process rights of employers. A more detailed discussion of the Administrative Procedures Act and suggested legislative language is provided in appendix 1 to this statement.

Section 11 of S. 1926 spells out the action the Secretary can take if an HMO fails to maintain its qualified status. Thus, this section begins to remedy an area of concern to many who considered as a major problem the lack of information on how the Federal Government was to regulate HMO's assisted or qualified under the act. Of the 299 respondents to our question concerning the lack of HEW regulations and guidelines on Federal continued regulation of HMO's, 71 percent indicated that such an absence of regulations was a hindrance to becoming a federally qualified HMO.

Section 11 of S. 1926 would, for HMO's that have been qualified under section 1310 of the HMO Act and have not received Federal financial assistance, restrict the Secretary of HEW's remedies for an HMO not meeting the requirements of the act. The remedy proposed is public and employer notification that the HMO is no longer qualified under the act. Such a limited sanction may not be enough to prevent an HMO from becoming qualified to gain the marketing advantage of dual choice, and then opt out of maintaining a qualified status once it has achieved its market penetration.

An effective remedy, which the committee may wish to consider, would be to provide for the loss of medicare, medicaid and/or Federal employee contracts if qualification status is not maintained.

Regarding the HMO's which have received Federal financial assist-

ance under the HMO Act and which fail to maintain a qualified status, we suggest that the amendments provide that among the other remedies available to the Secretary would be the right to suspend financial assistance and the right to recover all or some portion of Federal funds previously awarded.

As we have previously stated, sections 1314 and 1315 of the HMO Act require extensive program evaluations by—of HMO's by both GAO and HEW. While the requirements are essentially the same for the two agencies, significant differences are that the GAO must evaluate a specific number—50—of HMO's, must report several of its evaluations by December 1976, and must perform an additional study of the economic effects upon employers of the "dual choice" provision of the act.

Based upon our preceding testimony on the slow rate of progress in: (1) The HMO grant, loan and qualification programs; (2) the development of HEW's HMO evaluation strategy; and (3) the issuance of final regulations concerning "dual choice" and "continuing regulation," we believe that there will not be enough HMO's developed under the act for meaningful evaluation and report by December 1976. Further, we believe that a GAO report on the 50 HMO's possibly a decade or so after the passage of this act would be of little value to the Congress.

Also, satisfactory methodologies have not yet been developed to provide the comparative information and impact on health determinations called for by section 1314(c).

Under our current legislation authority—section 204 of the Legislative Reorganization Act as amended by section 702 of the Congressional Budget Act of 1974—we can and will perform HMO program evaluations as requested by Congress and its committees, and on our initiative. Our responsiveness in this manner would better meet the current information needs of the Congress and would be subject to Congress' and GAO's current priorities, not— as it is under section 1314—dependent upon the rate of HEW implementation of the act. Accordingly, we suggest that the present language of section 1314 be deleted. However, if the subcommittee desires that GAO evaluation be required by the act, we suggest that section 1314 be revised in accordance with suggested legislative language in appendix II. Briefly, the results of our suggested legislative language would:

Better meet the information needs of the Congress by substituting in lieu of the required evaluations of 50 HMO's an earlier review of selected HMO's certified by HEW as qualified operational entities. Such a review, if not limited to only those that successfully operated for at least 3 years, would provide more relevant and current information on the viability of the concept.

Accommodate the only foreseeable problem we have with the required section 1314(b) study of the economic effects on employers resulting from their compliance with the requirements of section 1310, by relating the issuance of a report to the Congress to the actual existence of HMO's qualified to utilize the dual choice provision of the act.

Recognize the fact that satisfactory methodologies have not yet been developed to provide the comparative information and impact on health determinations called for by section 1314(c). Further, this

latter section, if left unchanged, provides a significant administrative and budgetary problem for us because we do not have the skills and other resources at hand in sufficient amounts to develop the necessary evaluative mechanisms.

Mr. Chairman, this concludes our statement. We shall be happy to answer any questions that you or other members of the subcommittee might have.

Senator KENNEDY. I gather from what you have said here that the program has been significantly understaffed in terms of its requirements to implement the program. Would that be an unwarranted conclusion on my part, based on what you have stated?

Mr. MARTIN. I think that is a generally fair statement. I think both in the numbers of people and in terms of staff expertise required to process grant applications.

Senator KENNEDY. Now, you indicated that in some very important areas, they had one lawyer working on regulations; is that correct?

Mr. MARTIN. That is correct, sir. He spends 70 to 80 percent of his time working on the HMO regulations.

Senator KENNEDY. You mean the one lawyer spent 70 or 80 percent?

Mr. MARTIN. Yes, sir.

Senator KENNEDY. So you only had one lawyer and he was only spending 70 or 80 percent of his time?

Mr. MARTIN. That is correct, sir, and that was on a part-time basis.

Senator KENNEDY. On a part-time basis.

In your professional capacity, what kind of expertise would you need to try to develop regulations in an area that is as complex and as difficult as this? What is your kind of experience based upon? I know you can't say with exact precision, but you can give us something; are you talking about one person working full-time, or are you talking about 10 people working full time?

Mr. MARTIN. In terms of the legal problems?

Senator KENNEDY. Well, in terms of promulgating regulations for the legislation.

Mr. MARTIN. Oh, for both the professional type and the legal type. I don't know that we know precisely what the numbers would be. I think certainly if they were able to fill their authorized staff positions, it would certainly go a long way in speeding up the issuance of regulations.

They obviously would need some actuarial type people, financial type people, people that are really familiar with HMO's. Mr. Schulz has been working on this program and can probably tell you—

Senator KENNEDY. I would be interested in getting from you a staff pattern, but right now I am interested in just finding out realistically what they ought to be. You don't have to go into any great specificity, but I am interested in the nature of that responsibility.

Mr. SCHULZ. Well, the Assistant General Counsel for Health, HEW, did make available to us a time and motion study that was made by his office, and for those attorneys just dealing with health, they were short almost 100 percent of the positions they felt they needed at that point in time.

Senator KENNEDY. What does shortage of 100 percent mean?

Mr. SCHULZ. That means that the General Counsel for HEW is not funded out of any program appropriations, but funded out of the Sec-

retarial overhead. Thus, when additional legislation is passed—a new law is passed—they do not get additional legal staff assigned to deal with the obvious need to have regulations implemented so they have to draw from the folks that they already have aboard.

Senator KENNEDY. Either that or request additional personnel?

Mr. SCHULZ. Right, but they can't get it through the program budget, in this particular budget process. They have to get it as part of the Secretary's overhead, which is apparently subject to quite a bit of criticism on occasion.

And in this instance, you have a situation where the regulations were split up into several different documents to be published—In addition, you have—I think the last estimate was almost 40—different legal memoranda of precedent value, that this one attorney had to prepare. Plus all the questions that some HMO out in the field brings up, legal questions that you have to resolve. As it turns out, the Assistant General Counsel for Health has felt that he had to spend up to 25 or 30 percent of his time on occasion just on HMO's and he covers the whole health area for HEW, as far as legal questions are concerned.

Senator KENNEDY. Well, what is the implication of all of this from an administrative point of view?

Mr. SCHULZ. The implication for this is apparent because of the review process that HEW has for preparing regulations. We charted it once and there was something like 18 different checkpoints before a regulation could get issued as a notice of proposed rulemaking. Then, that again is repeated for final regulations. So you have as many as 36 checkpoints. The attorney—the General Counsel is involved in about one-third of those. The upshot is that you are going to have to expect a significant delay in the issuance of regulations to implement these laws, especially these very complex laws.

Senator KENNEDY. And has that been the result?

Mr. SCHULZ. I think the figures we cite in the statement are very important. The regulation on how the Federal Government is going to regulate an HMO once they sign on has yet to be issued as a notice of proposed rulemaking. And the other ones that we have mentioned—we have a range of something like 10 to 22 months to get regulations. Whatever the laws you write, they don't hit the streets until these regulations come out.

In addition, they have yet to issue final guidelines. To be specific, you might say a "basic service" is the provision of physician services. When you start to define who is a physician and what those services are—this comes out in the regulations and the guidelines—the nitty-gritty—much of that is still open. I mean the people out in the field—people on the street—still don't know exactly what the Federal Government requires of them under the HMO Act.

Senator KENNEDY. Well, how can they make an application that is going to make some sense, if they haven't even gotten final regulations?

Mr. SCHULZ. Well, we were concerned about this. In the beginning the decision was made because of the funding situation to develop the grant guidelines to get some of the money out. We felt there was a situation where they were giving out money to see if it was feasible to become a qualified HMO, to plan for a qualified HMO, to develop as a qualified HMO, initially. Yet, the regulations at that time as to what a qualified HMO should be had yet to be issued.

So there was a lot of guesswork. They have in the grant applications boiler plate language indicating that the grantee or the loan recipient will have to comply with the regulations when they are finally promulgated.

Senator KENNEDY. Not a very encouraging picture, I would think, for anybody who is interested in getting into the new program.

Mr. SCHULZ. I think that indicates one of the reasons, which HEW has mentioned before, for the hesitancy of some of the programs to come aboard because they don't know exactly what "Big Brother" is going to do to them.

Senator KENNEDY. I had wanted to get into the staffing personnel for new applications and the time it takes to process the applications. The proposed amendments would create a good deal of additional activity. What we are going to face in terms of additional times of delay.

Even now you say that it takes 84 man-hours.

Mr. SCHULZ. Eighty-four staff days to process the applications to become qualified.

Senator KENNEDY. Eighty-four staff days. Now how many staff do they have?

Mr. SCHULZ. They have seven.

Senator KENNEDY. How many applications do they have?

Mr. SCHULZ. At present, they have about 14 applications including those that they have to reprocess. On the last contact with HEW, they had 95 additional HMO type entities that have indicated that they want to apply.

As we again say in our statement, they will not be able to begin to process anything received from now until the end of the year until next year.

Senator KENNEDY. Well, if you figure mathematically, does it take $1\frac{1}{2}$ years to process the existing applications? I mean with the existing staff?

Mr. SCHULZ. Well, I haven't computed it out like that, but basically what you were saying is that any application that comes in now, especially after the issuance of dual choice regulations last month, they are just going to have to wait in line. And the length of time it is going to take them can be—we are talking now about 3 months—sure, if 95 come in, up to 6 months, it is a staffing problem. I think HEW has recognized that; we're not too sure what they are doing about it, but they have recognized it.

Mr. MARTIN. For the Office of Qualification they have an authorized strength of 15. In November, they had 14 applications either in process, awaiting process, or reprocessing.

You are talking about 84 days, assuming all seven people are working on that, yes.

Senator KENNEDY. You have seven people working on it, 84 working days, so it is 12 days. Is that right?

Mr. MARTIN. Yes, assuming everybody is working on one application.

Mr. SCHULZ. And that includes the secretaries and the clerks.

Senator KENNEDY. Well, what is the number of applications that you have now?

Mr. MARTIN. On board now, they have 14; 4 in process, and 10 awaiting processing, including 4 to reprocess as a result of the dual choice provisions.

Mr. SCHULZ. And their estimates were that if they had 15 folks on board, they could not handle those until the end of this year.

Senator KENNEDY. Well, that is almost a year, isn't it?

Mr. SCHULZ. It becomes more complicated if you tie in the fact that some of these qualification applicants also are applying for loans. In other words, they can only actually be financially viable with a Federal loan.

Senator KENNEDY. What would be your conclusion if we alter or change the statute to make it even easier for other groups to come on in? I would like, unless you have a strong commitment by HEW that they are going to expand staff personnel significantly, that there is a good possibility for even longer delays.

Mr. SCHULZ. The conclusions are rather obvious, in that they will have delays unless they do staff up, or do show a commitment to staff up. They will have a problem here. I think we have received indications since several of your colleagues, both in the Senate and the House, have expressed concern to HEW about projects in their districts who have been informed by HEW they have a 4 or 5 months wait for qualification. I am sure that this will increase.

Mr. MARTIN. I think HEW has recognized this in that they have discouraged the submission of some applications. If it is made easier, there will be more and more people trying to apply.

Senator KENNEDY. I would say it is not a good situation.

Senator SCHWEIKER. Do you have any legislative recommendations to this committee to help improve or reform this procedure? In other words, has that been included in any of your work?

Mr. SCHULZ. Well, regarding legal staff, we haven't prepared anything. We have had a discussion, in that when you have a timetable on a law—this is supposedly a 5-year demonstration project—there should be recognition within that 5-year timetable of the time it does take to prepare the regulations and the guidelines.

In this instance we are talking about, a 5-year program, of which 2 years is already gone by, for which significant action has not taken place, mainly because the law itself hasn't been implemented by regulations to the street. I think the House, in their discussions—however, it wasn't implemented—indicated putting timeframes on the implementation of those actions, by specifying when the regulations should be out, and to run the timetable on the law based on when the regulations are out.

Senator SCHWEIKER. In your investigative experience, how does this compare to, say, other new types of complex programs, in terms of being initiated, carried out, promulgated, or administered? What kind of benchmark could you give us as to whether and how this fits other patterns, where you have a new operation or a rather complex sort of operation?

Mr. MARTIN. We have not done anything that would give you that type of information. We do have in process now a review which is looking at the establishment of new regulations to try to determine how long it takes and why it takes so long to get regulations out.

Generally, it is a problem. We have not compared this particular piece of legislation with others to provide the kind of analysis you referred to. We hope to be able to.

Senator SCHWEIKER. Mr. Schulz?

Mr. SCHULZ. Well, I would just say that the only parallels I have are not direct, but there is a problem of rising expectations. In this instance, people in the prepaid health business had expectations back in December 1973—this is similar to other programs that we have looked at—and by having nothing come down for a couple of years, we have observed a fair amount of dissatisfaction with the program.

Senator SCHWEIKER. You make the point of how fragmented the utilization of skilled personnel is between the regional offices and the national headquarters of HEW; do you have recommendations on this? In other words, we have limited staff available, obviously some technical expertise required. Is this the kind of program we should—with a limited staff—really break down and give to the regional offices, or do we get a better, quicker utilization in this case, because No. 1, it is a small program and, No. 2, it requires a certain amount of expertise to keep a single unit functioning here in Washington?

Mr. MARTIN. Well, we have really not looked at the decentralization issue in this particular work. I think there are same advantages and also there are some disadvantages in decentralization.

One of the advantages, certainly, of decentralizing to the regions is the people working with the applicants are closer to the applicants and can make their site visits and become more involved and knowledgeable of the agencies out there.

As far as HEW is concerned, they have placed the HMO responsibility into one office—they have recently taken that action as a result of the concerns expressed in the House, and we are hopeful that this will improve the administration of this program.

They have basically centralized the headquarter's function, but they still have their regional offices involved in the applications.

Mr. SCHULZ. There are two additional points: one, of course, is that if there were regulations and guidelines out, the regional offices then could have one book to read from. That would eliminate some of the variation and would help, too, in that some of the expertise required would be reflected in the guidelines.

Second, the central office has been trying to and has hired generally on a 1-year basis, some people with specific expertise, who then have, as part of their role, to go out and assist the regions. But again, in the total number of people, they just don't have enough folks available to go out and help the regions.

Mr. MARTIN. I think it is not the organization as such—whether it is centralized or decentralized—but the need for additional people which are not available and has slowed the progress of this program.

Mr. SCHULZ. And another factor is that the Civil Service Commission is now doing audits of various organizations and the HEW field offices are—what they call—being re-looked at.

So, positions and grade levels in several other programs, including the HMO programs, have been lowered. It is the opinion of the regional people that they cannot offer salaries at a level competitive enough to get somebody with these skills.

Senator KENNEDY. The fact remains that even though it is a new program, it is not one that the administration is unfamiliar with. If you remember, Secretary Richardson came up in 1971 and talked to us about setting up a program for 800 HMO's at that time. This was one of their major health initiatives, initially.

In the Secretary's statement, it says 95 organizations have signified in writing their intent to submit qualification applications. This is against the earlier background where you are asking about the—I mean here, you have the Secretary saying that there are 95 organizations.

After finding out the number of person days that are necessary to process these, I think you are faced with an absolute administrative nightmare because you are not going to find, I don't believe, HEW prepared to come up and ask for additional personnel in these areas.

Even with the existing limitations it is going to continue to be an administrative nightmare if we open this thing up any more for additional kinds of applications beyond that.

This is a matter of very importance, at least to me and I am sure to other members of the Committee.

But, let me ask you this. You have indicated, in your testimony, that you have become aware that HEW has been giving consideration to plans to allow to expire a number of HMO grants funded in fiscal year 1975, primarily because the current projected HMO budget for grants cannot support continued funding.

Can you elaborate on that, and give us the justifications of why you believe that?

Mr. MARTIN. Yes, sir. I think, because of the \$15 million available for 1976, HEW believes it impossible with that type of funding to continue to fund existing HMO's and also some new applications.

Now, what they have tried to do is to establish some priorities and to look at the existing HMOs and to make determinations on which of those have the best possibility to continue and become operational. And, on that basis, I think that there are something like 60 HMO's who now have grants, who will not receive additional funds.

And, if that is the case, with the anticipated funding for 1977, and 1978, they are estimating something like 80 operational HMO's at the end of the 5-year demonstration period.

Senator KENNEDY. Does that mean that there are going to be some that are in existence now that have been prepared to take their chances on the promulgation of the number of regulations, finally get into business and then be terminated?

Mr. MARTIN. Terminated in the sense that they would not be given additional Federal financial assistance.

Senator KENNEDY. What possible sense does that make? Isn't that just a waste of a good deal of the taxpayer's money, let alone the more brutal aspects of false expectations and hopes? And, what is really even beyond that, the ability to provide important health services?

Mr. MARTIN. I think that the Department is faced with the reality of having only \$15 million to continue the program and they have to make some hard choices and go with those projects they feel have the best chance of becoming operational.

This is necessary because they cannot fund all the existing projects and consider any additional projects that might look like they would be worthy of Federal assistance.

Mr. SCHULZ. I should add, Senator, that the 60 we are talking about are in addition to what they would consider normal attrition rates. I also should add that I think based on similar work we did on the program prior to the HMO act, HEW did indicate their concern. We did take a pretty good hard look at the ones they did fund previously and this probably is one of the reasons they didn't use all their grant money up.

It is a problem for those HMO projects out in the field. I think it is the reality, though, of having \$15 million available to fund the existing program.

Mr. MARTIN. Yes; but in reality that is what they requested.

Senator KENNEDY. Now, what is the basis for your conclusions on that?

Mr. SCHULZ. Back in September—September 2 to be exact about it—the HMO program presented this issue to the administrator with three options, one of which was this early termination of projects, and another option being what they called a stretchout, enabling some of them to continue but giving less money to the various programs.

And the third one is to—as you indicated—ask for more money. The Administrator, on September 10, indicated that their experience was they cannot have any expectations of getting additional funds.

Thus, realistically, as Mr. Martin has indicated, they have to go with what they are going to get. And this is what the option was. In October they announced that they are going to implement this.

The Department then, monthly, with the regional people participating, will give an assessment of those HMO projects they believe can make it. I think that the Department could possibly give you, when they come up here, a statement as to how the implementation of this option is coming along.

Senator KENNEDY. Well, can you submit to us any material which you have that indicate decisionmaking?

Mr. SCHULZ. Certainly. We will include it in the record at the conclusion of our testimony.

Senator KENNEDY. Now to get back to the regulations, can you tell us about the time it is taking in the different areas, and the bottom line of final regulations that you—

Mr. SCHULZ. Guidelines.

Senator KENNEDY. Yes, guidelines.

Mr. SCHULZ. Yes, sir. We mentioned some specific regulations and how many months it took to issue since enactment.

Basically they have broken the regulations up into several subparts. And, on October 18, 1974, they issued a final regulation on the sub parts that primarily dealt with financial assistance aspects—grants and loans. This October issuance had, in addition, a restatement of section 1311, the State law override.

On August 8 of this year, they issued final regulations on qualification or in other words, the process by which HMO's could apply for qualification.

And, on October 28 of this year, they issued the regulations on employees health benefits, the dual choice aspect. There was quite a bit of debate on the role that the union had in the dual choice situation.

Regulations on how HMO's are to be regulated have not been issued. Of course the amendment before you addresses this specifically with legislative language.

They also have issued regulations on medically underserved areas which listed all the medically underserved areas. They issued that on September 2, 1975.

The regulations on Indians—and how Indian prepayment authority would be utilized—I think it is section 6 of the HMO Act—have yet to be issued.

Senator KENNEDY. On the issue of open enrollment, as of November 14 the requests or the number of requests for waiver had been submitted, but final action has not been taken because HEW criteria review of the circumstances justifying waiver have not been prepared. This is 24 months after the enactment, is that correct?

Mr. MARTIN. They have not made a final decision on how they are going to handle the situation.

Mr. SCHULZ. Now they have, of course, the regulations which tell the HMO's what they are supposed to use as reasons for a waiver of open enrollment, but within the Department the procedures by which they would look at that application and say that, "yes we will give it or no we will not give you a waiver"—they have not yet processed.

This happens to be the responsibility of that office we talked about already being understaffed—the qualification office. This is an additional responsibility of theirs.

Senator SCHWEIKER. What percent in your questionnaire said open enrollment was a noncompetitive feature?

Mr. MARTIN. We sent out questionnaires, as you said, to over 800 agencies. Three hundred agencies responded to the open enrollment question; 142, or 46 percent, stated that it would make them noncompetitive. So of the 300 responding, 142 said that it had a noncompetitive impact.

Senator SCHWEIKER. How about community rating?

Mr. MARTIN. Community rating—we had 307 responding to that question. And, 135 of those, or 44 percent, stated that that would make HMO's noncompetitive.

Senator SCHWEIKER. How many said, in essence, that the basic and supplemental benefits would make it noncompetitive?

Mr. SCHULZ. 170, or 56 percent of the 360 responding said that it would make them noncompetitive.

These 56, 46, and 44 percents are majority responses of those who expressed an opinion.

Senator SCHWEIKER. How many said the supplemental benefits would make it noncompetitive?

Mr. SCHULZ. The question was all-encompassing, but we do ask them specifically about certain basic benefits.

Senator SCHWEIKER. I am sorry, about alcohol, drug abuse, and preventive dental care?

Mr. SCHULZ. We asked a specific question and of those who did respond to those points, 48 and 40 percent responded to those two

areas, alcohol, drug abuse, and preventive dental care were the ones that made it noncompetitive.

Senator KENNEDY. What has been the result of HEW implementing the preemption of State laws?

Mr. MARTIN. On that particular item the same problem exists that exists in some of the other areas. HEW really is not taken a position as to how they are going to really handle it.

What they have agreed to do is handle it on a case-by-case basis. And once all the other alternatives that are available to HMO's have been exercised, they would provide financing to HMO's to assist in removing the restrictions in the State law.

One thing that concerns and bothers us is that you could go through a process of giving HMO's substantial Federal financial assistance and then have a problem with the State law in going operational. It could be quite a problem.

But they have not, as yet, established an overall policy on how they address that potential problem. They do have a consultant that provides some technical assistance to HMO's for this area.

Senator KENNEDY. You don't know why. It was in the law, and I don't understand why it hasn't been implemented. Did you draw any conclusions as to why not?

Mr. MARTIN. I have not. No, sir.

Mr. SCHULZ. Again, it is a situation where, obviously this is where the General Counsel staff would have to——

Senator KENNEDY. Yes, the fellow who is working there.

Mr. SCHULZ. We, as part of our review, did ask the regional attorneys of all 10 HEW regions and regional representatives their views on the situation. The majority of those we talked to said that that would be a headquarters responsibility, or something like that.

I think we summed it up that the HEW decision was not to act except in a specific case-by-case basis. The House bill, H.R. 9019, does have a section addressing this problem, which indicates that HEW should notify the Governors of the States where these laws are restricted.

Senator KENNEDY. We will include the rest of your statement in the record and perhaps have some written questions.

[The prepared statement of Mr. Martin along with attachments follow:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

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STATEMENT OF
JAMES D. MARTIN, DEPUTY DIRECTOR
MANPOWER AND WELFARE DIVISION
BEFORE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR
AND PUBLIC WELFARE
U.S. SENATE
ON
THE IMPLEMENTATION OF THE HEALTH
MAINTENANCE ORGANIZATION
ACT OF 1973

Mr. Chairman and Members of the Subcommittee, I am pleased to appear here today to discuss our current review on the implementation of the Health Maintenance Organization (HMO) Act of 1973. The review was initiated to provide Congress with information on: (1) Department of Health, Education, and Welfare (HEW) management actions needed to accomplish congressional objectives in an efficient and effective manner; and (2) legislative changes, if any, needed to accomplish stated objectives for HMO development. My statement will provide information on the

implementation of the HMO program by HEW and our views on (1) the HMO Act amendments proposed by S. 1926 and (2) other changes to the HMO Act which the Subcommittee may wish to consider.

THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973

The HMO Act of 1973 (87 Stat. 914) approved December 29, 1973, amended the Public Health Service Act to provide a trial Federal program to develop alternatives to the traditional forms of health care delivery and financing by assisting and encouraging the establishment and expansion of HMOs.

The act spells out in considerable detail, the definition of and the requirements for an HMO. Among other things, the act specifies the basic and supplemental health services to be provided the HMO membership, the basis for fixing the rate of prepayment, the requirement that HMOs have open enrollment periods for individual members without restrictions (such as preexisting medical conditions), and the organizational structure of an HMO.

The act authorizes a 5-year demonstration program designed to promote the development of new, and the expansion of existing HMOs by:

- providing financial assistance through grants, contracts and loans;
- providing a market for HMOs by requiring certain employers to include in any health benefits plan offered to employees the option of membership in an HMO that the Secretary of HEW has "qualified" to be in compliance with the requirements of the HMO Act and

--removing restrictive State laws and practices which could serve to hinder the development and operation of a qualified HMO.

PROGRESS IN IMPLEMENTING THE ACT HAS BEEN SLOW

As of June 30, 1975, HEW had received 375 grant applications for about \$59 million and had awarded 180 grants totaling about \$22.5 million to 157 projects.

As of November 14, 1975, HEW had received 54 fiscal year 1976 grant applications for about \$10.6 million and had awarded about \$3.0 million to 8 projects. Thirty-three of the 54 were new applicants which had not been previously funded under the act and processing of the new applications is not scheduled to be completed until January 1976.

By November 14, 1975, HEW had also "qualified" seven HMOs but such qualification for four of the seven was only for the purpose of eligibility for HMO loans and initial development grants for expansion purposes. The qualification of **one** additional HMO is awaiting the final commitment of a Federal HMO loan. As of November 14, 1975, five of the seven had received HMO loans or loan commitments which totaled about \$7.8 million.

Slow progress in implementation of the HMO program is evident in that HEW had not used over \$17.5 million of the \$40 million in grant funds which were available for fiscal years 1974 and 1975. Further, the Administration has requested only \$15 million of the \$85 million currently authorized for grants in fiscal year 1976.

We have recently become aware that HEW has under consideration plans to allow to expire a number of HMO grant projects funded in fiscal year 1975 primarily because the current and projected HMO grant budget cannot support continued funding.

Also, as of this date, final regulations had not been published in the Federal Register for implementing a critical section of the act dealing with the form of HEW's continued regulation of HMOs assisted by or qualified under the act. Final regulations implementing the funding criteria for the HMO grant and loan programs were published about 10 months after enactment of the law and the final regulations outlining the process of obtaining qualification of an HMO were published about 19 months after enactment. Final regulations implementing the "dual choice" offering of HMOs by employers in health benefits plans were published on October 28, 1975,--approximately 22 months after the passage of the act.

As part of our review, we sent a questionnaire survey to about 800 entities who had been identified by HEW's Regional Offices as those, nationwide, likely to seek the financial assistance under the act. Five hundred and sixty-two or about 73 percent of the 768 locatable entities responded. This survey, along with other recently published studies, indicates that there are entities who wish to participate in the Federal HMO program, but for various reasons, have chosen not to. These reasons include the lack of final regulations and basic disagreements with certain sections of the act and with certain actions of HEW.

We will specifically discuss some of the information provided in response to our questionnaire later in our statement.

FINDINGS ON HEW'S ABILITY
TO IMPLEMENT THE ACT

During our review of the implementation of the HMO Act, we have observed that no single organizational unit within HEW is responsible for the entire HMO program. The HMO program has been decentralized to 10 regional offices and functionalized within various headquarters offices but HEW has not developed a system to coordinate program activities or to account for the utilization of staff resources.

The primary responsibility for administering the grant, loan, and technical assistance programs for HMOs rests with the Office of HMOs which was, until November 7, 1975, part of the Bureau of Community Health Services of the Health Services Administration (HSA). The Office of HMOs was one of six program offices within the Bureau of Community Health Services, which also has five functional divisions and two administrative support offices for such activities as policy development, monitoring and analysis and health services financing. These divisions and offices are staffed from the resources appropriated to the programs.

Bureau of Community Health Services officials maintained that the HMO program was obtaining staff years of effort equivalent to the number of staff positions authorized for the program but we found that the Bureau had no formal system to account for utilization of its authorized staff resources other than assuming if a particular task was accomplished on time, all staff resources were used. Thus, while

the Bureau may have estimated that it required 1,200 staff days to accomplish a task, e.g., issue regulations by a certain date, it had no ongoing management information system to determine whether it used 200, 1,200 or 2,000 staff days, nor could it determine the amount of time each office or division staff worked on the task.

During the July hearings on the House of Representatives' version of the HMO Amendments of 1975, concern was expressed that some of the HMO program's difficulties were partly attributable to the way the program was being administered by the Department. Section 14 of the House bill (H.R. 9019) approved by the House on November 7, 1975, would require HEW to administer the HMO program, excepting the qualification and regulation activities, through a single identifiable unit of the Department.

In response to the concerns expressed by the House, the Acting Assistant Secretary for Administration and Management, HEW, approved on November 7, 1975, a proposal to consolidate the HMO program staff positions then functionally distributed in the Bureau of Community Health Services, as one office within another HSA Bureau--The Bureau of Medical Services.

The 10 regional offices have responsibilities which include the monitoring of and providing technical assistance to the HMO grant and loan projects. The Regional Health Administrators report directly to the Office of the Assistant Secretary for Health and are not accountable to the Administrator of HSA or other agency heads.

At the time of our regional review in the Spring of this year, we found that the Bureau of Community Health Services had no management information system to trace or account for regional staff resources. Some

regions did fill out monthly reports in which they estimate how many days were spent on such activities as monitoring, technical assistance, and grant application review, to help determine if they are meeting work plan objectives. All regions are scheduled to prepare such reports in fiscal year 1976.

The qualification and regulation of HMOs are the responsibility of an HSA office separate from the Bureau and the regional offices. This office of HMO Qualification and Compliance was officially established in June 1975 and is presently hiring staff to reach its authorized fiscal year 1976 level of 15 positions.

Number and type of staff resources available

Information provided by our review indicates that HEW does not have the number and type of personnel needed to implement the program. This has resulted in the lack of uniformity among the HEW regional offices in carrying out their responsibilities for HMO grant award review, grant monitoring and the provision of technical assistance to HMO grantees. Thus, the access to a National program of HMO development varies from region to region. We were told of instances where a regional office has actively discouraged the submission of grantee applications due to a lack of staff to process the applications and where regional offices were unable to make staff resources available for assistance to potential grant applicants. (We should note that discouragement of additional grant activity when there is a lack of staff to adequately administer the Federal program and funds may be a prudent action.)

In February 1974, the Administrator of HSA allocated 50 positions for the HMO program to the Regional Offices. In September 1975, 46 (33 professional and 13 clerical) regional positions were filled. This does not mean, however, that 46 people are working full-time

on the HMO program. While work plans prepared by the Regional Health Administrators commit a total of 50 staff year equivalents to the HMO program, they do not have to identify to HSA the specific individuals working on HMOs. Our review in the spring of 1975, found, however, that individuals filling regional HMO professional positions were working on HMOs, at least the majority of their time, if not full-time. The individuals in the HMO clerical positions were not necessarily working on HMOs, even part-time, since there was a shortage of clerical-secretarial help in some of the regions and such employees were used wherever needed.

While some regional offices are not providing technical assistance to grantees partly because of a shortage of staff, the problem is not only with quantity but also with staff expertise. When the Administrator of HSA allocated 50 positions to the regional offices, he emphasized the need for specialists in the areas of marketing, actuarial analysis and financial management who also have a knowledge of prepaid health plans. Few regions have filled their positions with the personnel that have this expertise. Most of the regional staff are generalists who have expertise in health care delivery systems, hospital administration, disease control or Federal grants management and usually a general knowledge of prepaid health care. Several regional officials told us that individuals with the desired expertise will not work for the Federal Government at the grade levels and salary offered.

The lack of an adequate number of staff with expertise is also a problem in the headquarters operations. For example, one contributing factor to the delay in issuing final regulations to implement the HMO program is the lack of legal staff. Since January 1974, there has been only one staff attorney assigned, part-time, (70 to 80 percent) to the HMO program. The Assistant General Counsel for Health considers this staffing level too low considering the number of regulations and related legal opinions required by the HMO program.

As of November 14, 1975, the Office of HMO Qualification and Compliance had three professionals and 4 clerical-secretarial staff members (only three of the clerical-secretarial staff were hired as part of officially authorized 15 positions--the others being on loan from the Bureaus or assigned directly to the Administrator of HSA). The Office, at that time, had 7 HMO qualification applications in process, 10 applications awaiting processing and 4 HMOs qualified previous to the issuance of final "dual choice" regulations to reprocess. We were informed that the processing of an application takes an average of 84 staff days and even if the 15 positions were filled, any additional applications which came this calendar year could not begin processing until early 1976.

Use of CHP Agencies and Medical Society Notification

The HMO Act of 1973 recognized the need for community and professional acceptance of HMOs as a necessary prerequisite for successful development of the concept, by requiring review and

comment by Comprehensive Health Planning agencies (CHPs) on grant and loan applications and Medical Society notification of certain grant applications.

Final regulations published in October 1974, set out specific aspects of a grant or loan application that need CHP review and comment. We were informed at all of the Regional Offices that the CHP comments were general in nature, were not submitted within the prescribed 60 days in several instances, and did not comply with the regulations. The HMO personnel stated that several CHPs did not have the staff resources to adequately review HMO applications. Regional officials responsible for CHPs generally confirmed this observation.

We further found that the CHP comments that were received by some regions had little impact on the grant review process and there was significant variation in the regional office use of the CHP comments. For example, some regions virtually ignored the CHP role and completed their grant review process before the CHP comments were due. On the other hand, some regions not only included the CHP comments in the formal grant review process, but met with CHP officials during the preaward site visits.

In our questionnaire, we asked both those who did and did not apply for financial assistance under the act, what degree of support or opposition to their application (or their

intent to apply) came from the CHPs and medical societies. The majority of respondents who did contact the CHPs and medical societies, indicated that they received support or at least did not receive opposition. However, 41 of the 225 respondents to the question said that they had encountered opposition from the local medical societies. Fifteen of the 41 or about 37 percent were in Region VI (Dallas), 8 or about 20 percent were in Region V (Chicago), 5 or about 12 percent were in Region IX (San Francisco), 4 or about 10 percent in Region IV (Atlanta), and the balance were scattered among four other regions. No opposition was reported by respondents in Regions III (Philadelphia) and VIII (Denver).

Program Evaluations

The HMO Act requires extensive program evaluations by HEW and GAO.

Section 1315 of the act requires the Secretary of HEW to make an annual report to the Congress on HMO program activities which includes

- a summary of grant and loan awards,
- findings with respect to the ability of HMOs assisted under the act (1) to operate on a fiscally sound basis without continued Federal assistance, (2) to meet the organization and operation requirements of section 1301,

(3) to include indigent and high-risk individuals in their membership, and (4) to provide services to medically underserved populations.

Also, HEW is to report on findings with respect to

- the operation of distinct categories of HMOs in comparison with each other,
- HMOs as a group in comparison with alternative forms of health care delivery, and
- the impact of HMOs on the health of the public.

Section 1314 of the act places similar evaluation requirements on GAO with three exceptions; (1) we do not have to make an annual report to the Congress on these areas; (2) in addition we must evaluate 50 HMOs financially assisted under the act after they have been delivering services for at least 36 months; and (3) we must also conduct a study of the economic effects on employers resulting from their compliance with the requirements of section 1310, the dual choice provisions of the act. This latter study and GAO's evaluation of the operations of distinct categories of HMOs, HMOs in comparison with alternative forms of health care delivery and the impact of HMOs on the health care of the public, are due in December 1976.

To avoid placing duplicate information demands on HMOs we would like to utilize the data that HEW obtains from the HMOs to meet our evaluation requirements.

HEW has developed data reporting requirements which will not, in our opinion, provide sufficient information for the evaluations required by section 1315. HEW will rely on special studies to meet its evaluation requirements. In fiscal year 1975, there were three special studies prepared at a total cost of about \$93,000 which analyzed potential and existing operational prepaid plans with regards to the: (1) barriers to participation in the Federal programs authorized by the HMO Act; (2) economic viability of an HMO serving a rural population, and; (3) cost competitiveness of HMOs to other prepaid plans and group health insurers in selected metropolitan areas.

The responsibility for HEW's evaluations has been dispersed to two separate operating groups within the HSA. Since the passage of the act, one of these groups has undergone significant turnover in staff while the other had made several reassignments of the evaluation responsibility within the group. In September 1975, the two HSA groups had started to initiate working agreements on how to establish priorities for the evaluations. However, by November 14, 1975, funding for the proposed fiscal year 1976 HMO special studies had not been approved. The proposed HMO evaluation effort is three studies with a total budget of about \$65,000.

COMMENTS ON S. 1926

Basic and Supplementary Health Services

S. 1926 includes proposed amendments (sections 2 and 5) which would reduce the scope of basic health services to be provided by HMOs and would allow HMOs, at their option, to provide certain supplementary health services. Certain services now required to be delivered by HMOs would be considered supplementary health services, which, in the amendments are enacted as proposed, would not have to be made available by HMOs.

Our questionnaire asked if the basic health service requirements in the act would make HMOs noncompetitive with other types of health benefit plans. One hundred and seventy, or 56 percent of the 306 who responded on this matter stated that the comprehensive package of basic and supplementary health services required by the act would make HMOs noncompetitive. Further analyses of the responses to this question showed that of the 194 respondents who indicated they were delivering health services, there were 30 prepaid providers, 114 fee-for-service providers, and 50 combination (prepaid and fee-for-service) providers. Forty-seven percent of the prepaid providers, 50 percent of the fee-for-service providers and 68 percent of the combination type providers indicated that the required benefit package made HMOs noncompetitive.

Of the basic services currently required by the act, treatment and services for alcohol or drug abuse and preventive dental care for children, were identified by about 48 and 40 percent, respectively, of 301 respondents to these points as those which they agreed made HMOs too expensive and noncompetitive.

Open Enrollment

Section 4 of the proposed amendments would delete the "open enrollment" requirement in the act. Of the 308 respondents to our questionnaire on this matter, 142 or 46 percent stated that they

agreed that requiring "open enrollment" periods for HMOs would make them noncompetitive. Seventy-one or 23 percent disagreed and 95 or 31 percent had no firm opinion or had no basis to respond. Sixty percent of the 30 respondents who were delivering health services on a prepaid basis indicated that the "open enrollment" requirement would make HMOs noncompetitive. The HMO Act currently allows the Secretary of HEW to waive the "open enrollment" requirement and regulations issued October 18, 1974, outline the waiver process. As of November 14, 1975, seven requests for a waiver have been submitted but final action had not been taken because HEW criteria to review the circumstances justifying a waiver have not been prepared.

Community Rating

The HMO Act requires HMOs to establish premiums based on a community rate rather than on an experience rate. This means that HMOs cannot establish prepayment rates based on health utilization experience, age, or sex differences among groups to whom they market. HMOs must establish one community rate which applies to all members. One of the purposes for community rating is to spread equally among all HMO members the financial costs for comparable coverage.

Of the 307 respondents to the "community rating" question on our questionnaire, 135 or 44 percent stated that community rating requirements make HMOs noncompetitive; 79 or 26 percent disagreed and 93 or 30 percent had no opinion or no basis to respond.

Section 6 of S. 1926 proposes to delay the imposition of the community rating requirement until 5 years after an HMO becomes "qualified." We have no information which indicates that such a delay

will contribute to the eventual success of an HMO. Additionally, the full impact of community rating under the act is unclear since program guidelines containing the HEW interpretation of how community rating should translate into a premium rate structure, have yet to be published.

Loan Guarantee Program

S. 1926 includes proposed amendments (sections 8 and 9) which would expand the loan guarantee program by eliminating the requirement that for profit HMOs must serve medically underserved areas to be eligible for the loan guarantee program and making the loan guarantee program available to nonprofit HMOs.

Our review disclosed that HEW has not developed uniform policies and procedures for administering and monitoring the loan and the loan guarantee program--loans which have been made were handled on a case-by-case basis and HEW has not yet used the loan guarantee authority. HEW also does not have the number of experienced personnel, especially in the field, needed to effectively monitor the loan and the loan guarantee program.

If additional activity results from enactment of the amendments then HEW will definitely need additional personnel as well as uniform operating policies and procedures.

Dual Choice Provision

Section 1310 of the HMO Act says that every employer with at least 25 employees, who is required to pay the minimum wage and who offers health benefits to its employees, is to offer, as a choice,

the option of joining a qualified HMO. This is the so called "dual choice" provision. Section 10 of S. 1926 would lessen the administrative burden placed on employers by providing that an employer does not have to consider an HMO under the "dual choice" provision unless 25 or more of his employees reside in the HMO's service area. We favor this amendment but question whether the Federal Government should be excluded as an "employer" as proposed by another amendment to section 1310. (Section 10(f) of S. 1926.)

It appears to us that the exclusion of the Federal Government from the "dual choice" provisions denies a substantial market to developing HMOs.

H.R. 9019 addresses our concerns while retaining the exclusion of the Federal Government from the "dual choice" provisions by revising the U.S. Code sections (5 U.S.C. 8092, 8903(4)) which governs the Federal employee's health benefits program. Section 9b of H.R. 9019 would require the Civil Service Commission to contract with an HEW "qualified" HMO that also meets Civil Service Commission requirements.

While we can support the basic thrust of the proposed subsections 10(2) and 10(3) of S. 1926 which would delete the criminal sanctions made applicable by section 1310(c) in favor of the imposition of a civil penalty by the Secretary of HEW, we feel that this proposed amendment should refer to the Administrative Procedures Act (5 U.S.C., §§54-57 and 706) for administrative and judicial procedures to be followed and to better protect the due process rights of employers.

A more detailed discussion of the Administrative Procedures Act and suggested legislative language is provided in appendix I to this statement.

Qualified Status Not Maintained

Section 11 of S. 1926 spells out the action the Secretary can take if an HMO fails to maintain its "qualified" status. Thus, this section begins to remedy an area of concern to many who considered as a major problem the lack of information on how the Federal Government was to regulate HMOs assisted or qualified under the act. Seventy-one percent of the 299 respondents to our question concerning the lack of HEW regulations and guidelines on Federal continued regulation of HMOs, indicated that such an absence of regulations was a hindrance to becoming a Federally qualified HMO.

Section 11 of S. 1926 would, for HMOs that have been qualified under section 1310 of the HMO Act and have not received Federal financial assistance, restrict the Secretary of HEW's remedies for an HMO not meeting the requirements of the act. The remedy proposed is public and employer notification that the HMO is no longer qualified under the act. Such a limited sanction may not be enough to prevent an HMO from becoming qualified to gain the marketing advantage of "dual choice," and then opt out of maintaining a qualified status once it has achieved its market penetration.

An effective remedy, which the Committee may wish to consider, would be to provide for the loss of Medicare, Medicaid, and/or Federal employee contracts if qualification status is not maintained.

Regarding the HMOs which have received Federal financial assistance under the HMO Act and which fail to maintain a qualified status, we suggest that the amendments provide that among the other remedies available to the Secretary would be the right to suspend financial assistance and the right to recover all or some portion of Federal funds previously awarded.

SUGGESTED ADDITIONAL AMENDMENT TO THE HMO ACT

Program Evaluations

As we have previously stated sections 1314 and 1315 of the HMO Act require extensive program evaluations of HMOs by both GAO and HEW. While the requirements are essentially the same for the two agencies, significant differences are that GAO must evaluate a specific number (50) of HMOs, must report several of its evaluations by December 1976, and must perform an additional study of the economic effects upon employers of the "dual choice" provision of the act.

Based upon our preceding testimony on the slow rate of progress in (1) the HMO grant, loan and qualification programs; (2) the development of HEW's HMO evaluation strategy; and (3) the issuance of final regulations concerning "dual choice" and "continuing regulation"--we believe that there will not be enough HMOs developed under the act for meaningful evaluation and report by December 1976. Further, we believe that a GAO report on the 50 HMOs possibly a decade

or so after the passage of this act, would be of little value to the Congress.

Also, satisfactory methodologies have not yet been developed to provide the comparative information and impact on health determinations called for by section 1314(c).

Under our current legislation authority (section 204 of the Legislative Reorganization Act as amended by section 702 of the Congressional Budget Act of 1974), we can and will perform HMO program evaluations as requested by Congress and its committees and on our initiative. Our responsiveness in this manner would better meet the current information needs of the Congress and would be subject to Congress' and GAO's current priorities, not, as it is under section 1314, dependent upon the rate of HEW implementation of the act. Accordingly, we suggest that the present language of section 1314 be deleted. However, if the Subcommittee desires that GAO evaluation be required by the act, we suggest that section 1314 be revised in accordance with suggested legislative language in appendix II. Briefly, the results of our suggested legislative language would:

--Better meet the information needs of the Congress by, substituting in lieu of the required evaluations of 50 HMOs, an earlier review of selected HMOs certified by HEW as qualified operational entities. Such a review, if not limited to only those that successfully operated for at least 3 years, would provide more relevant and current information on the viability of the concept.

--Accommodate the only foreseeable problem we have with the required section 1314(b) study of the economic effects on employers resulting from their compliance with the requirements of section 1310, by relating the issuance of a report to the Congress to the actual existence of HMOs qualified to utilize the dual choice provision of the act.

--Recognize the fact that satisfactory methodologies have not yet been developed to provide the comparative information and impact on health determinations called for by section 1314(c). Further, this latter section, if left unchanged, provides a significant administrative and budgetary problem for us because we do not have the skills and other resources at hand in sufficient amounts to develop the necessary evaluative mechanisms.

Mr. Chairman this concludes our statement. We shall be happy to answer any questions that you or other members of the Subcommittee might have.

SUGGESTED REVISIONS TO SECTION 10 OF S. 1926

Recommendation 72-6 of the Administrative Conference of the United States, December 14, 1972, favored the adoption of an administrative procedure for imposing civil money penalties for agencies faced with routine enforcement cases. We suggest that the Committee embrace the Conference recommendations and draft legislative language which provides:

- for adjudication on the record pursuant to the Administrative Procedure Act (5 U.S.C., §554-57);
- that a determination by HEW is final unless appealed to the United States Court of Appeals within a specified period of time;
- that review of an administrative decision by the United States Court of Appeals be pursuant to the substantial evidence rule of the Administrative Procedure Act (5 U.S.C., §706(e));
- that issues made final by HEW's decision and issues which were raised or could have been raised on appeal cannot be raised as a defense to a suit brought by the United States to collect the penalty;
- that HEW be permitted to settle or compromise any of the civil penalties either before or after assessment.

This could be accomplished by the substitution of the following language in lieu of that proposed by S. 1926 as section 1310(e)(2) and (3):

"(2) In any proceeding by the Secretary to assess a civil penalty under this subsection, no penalty shall be assessed until the employer charged shall have been given notice and an opportunity to present its views on such charge. Adjudication of any such charge shall be of record and pursuant to the Administrative Procedure Act, 5 U.S.C., §§554-57. Any civil penalties provided under this section may be compromised by the Secretary. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification by the Secretary of a noncompliance.

"(3) A decision of the Secretary pursuant to a hearing shall be final unless appealed within 30 days to the United States Court of Appeals which shall have authority to review such decision under the substantive evidence rule as provided in the Administrative Procedure Act, 5 U.S.C., §706. Issues made final by reason of a decision of the Secretary pursuant to a hearing as provided herein and issues which were raised, or might have been raised, in a proceeding for review by the United States Court of Appeals may not be raised as a defense to suit by the United States for collection of the penalty imposed under this section."

Also, subsection 10(3) of S. 1926 needs to be clarified as to whether a separate penalty is to be assessed for each count of noncompliance by an employer or whether there is a \$10,000 ceiling to be imposed on the employer for all refusals to comply with section 1310. Section 9a of H.R. 9019 proposes that each 30-day period of noncompliance would warrant assessment and collection of a penalty.

SUGGESTED REVISIONS TO SECTION 1314 OF
THE HMO ACT OF 1973

Section 1314(a) is amended by striking out the matter after (a) and inserting in lieu thereof the following:

The Comptroller General shall evaluate the operations of at least 10 or one-half (whichever is greater) of the Health Maintenance Organizations for which assistance was provided under section 1303, 1304, and 1305, and which have been designated by the Secretary as qualified Health Maintenance Organizations by December 31, 1976, in the manner prescribed by section 1310(d). The Comptroller General shall report to the Congress the results of the evaluation by June 31, 1978. Such report shall contain findings:

- "(1) with respect to the ability of the organizations evaluated to operate on a fiscally sound basis without continued Federal financial assistance,
- (2) with respect to the ability of such organizations to meet the requirements of section 1301(c) respecting their organization and operation,
- (3) with respect to the ability of such organizations to provide basic and supplemental health services in the manner prescribed by section 1301(b),
- (4) with respect to the ability of such organizations to include indigent and high-risk individuals in their membership, and
- (5) with respect to the ability of such organizations to provide services to medically underserved populations."

Section 1314(b) is amended by striking out the matter after (b) and inserting in lieu thereof the following:

The Comptroller General shall also conduct a study of the economic effects on employers resulting from their compliance with the requirements of section 1310. This study should be conducted concurrent with the evaluations of qualified Health Maintenance Organizations required by subsection (a).

Section 1314(c) is amended by striking out the matter included in its entirety.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
OFFICE OF THE ADMINISTRATOR

: Acting Director
Bureau of Community Health Service

DATE: September 10, 1975

FROM : Acting Administrator

SUBJECT: Issue Paper on HMO Funding Options

I have reviewed the proposed Action Memorandum to the Assistant Secretary for Health forwarded by your memorandum of September 2, and I do not plan to submit this document to Dr. Cooper. There is no point in submitting another FY 1976 supplemental budget request and an implied increase in the FY 1977 allowance; these have been rejected on several occasions. We were unable to convince OMB that the HMO legislation should be extended for more than one year or that the authorization level should be more than \$18 million per year. Secondly, the Department never responded formally to the funding paper submitted earlier this year. Thirdly, several appeals to raise the FY 1977 allowance above \$18 million have been rejected. Therefore, the Congressional legislation and budget processes will have to make the final determination.

With respect to the two options under the reduced budget levels, we should proceed with the plan as outlined in the FY 1977 budget justification submitted to OMB; this represents Option 1. There are discrepancies in the tables with respect to FY 1975 operations; note page 34 of the OMB budget submission as compared to Tabs C, E and F of the option paper.

If there are further questions or issues of which I may not be aware, Dr. Seubold, you, and I can meet on this matter.

Robert van Hoek M.D.
Robert van Hoek, M.D.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
Bureau of Community Health Services

Acting Administrator
9/5/75

DATE: SEP 2 1975

FROM : Acting Director

SUBJECT: Issue Paper on the Options for Health Maintenance Organization (HMO)
Funding in Fiscal Year 1976 - ACTION

ISSUE

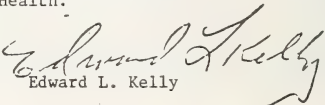
An early decision is required on which of several optional funding plans should be adopted for the HMO program in fiscal year 1976, since it is highly probable that grant funds will be less than required to support all eligible fiscal year 1975 grantees.

BACKGROUND

Circumstances which led to the need for revision of the HMO funding plan for fiscal year 1976 and the out years are detailed in the enclosed action memorandum. Three options for action are presented for decision.

RECOMMENDATION

That you sign the enclosed action memorandum (Tab A) for transmittal to the Assistant Secretary for Health.


Edward L. Kelly

Enclosure:

Tab A - Memorandum from Acting Administrator
to the Assistant Secretary for Health

Prepared by: BCHS/HMO, FSEUBOLD, 8/28/75, x34106

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
OFFICE OF THE ASSISTANT SECRETARY

TO : The Assistant Secretary for Health
Through: ES/PHS _____

DATE:

FROM : Acting Administrator

SUBJECT: Impact of the Fiscal Year 1976 Budget on the Output of the Health Maintenance Organization (HMO) Program and Recommended Action Needed to Proceed with Fiscal Year 1976 Grant Awards - ACTION

ISSUE

The strong probability exists that funding for the HMO program for fiscal years 1976, 1977, and 1978 will be reduced in comparison to fiscal year 1975 funding. This prospect requires action to increase fund availability or to restructure the current program funding plan. An early decision is needed, because funding applications from existing projects are being received now. Based on budget periods for existing grants, the volume of requests could be as large as \$10,000,000 by October 31.

BACKGROUND

In the months since HMO legislation was enacted, a series of HMO program funding plans has been developed in response to:

1. authorized levels;
2. Office of Management and Budget (OMB) concerns about program scope; and
3. internal directives concerning future budgets developed within the Department.

Development of each funding plan required estimates of future fund availability to ensure an orderly sequence of developmental activities within the authorized period.

The plan in effect during the first half of fiscal year 1975 was based on departmental acceptance of a fiscal year 1976 budget of \$50.184 million for grants and program operations. The President's budget for fiscal year 1976 provided \$18.6 million for the HMO program. This

budget amount was set in spite of the departmental appeal. Hence, the Secretary requested an assessment of the impact of the President's budget on the HMO program in his January 29, 1975, Management Conference.

Resource papers submitted subsequent to the Management Conference outlined alternative courses of action and associated consequences. While issues raised in the Management Conference papers were under review, the HMO grant program was maintained in full operation throughout fiscal year 1975. Five grant cycles were carried out with the approval of the Administrator, Health Services Administration (HSA), and the Director, Bureau of Community Health Services (BCHS). A total of \$22.5 million was obligated in 172 awards to 157 grantees.

For fiscal year 1976, the probable availability of grant funds is only \$15 million. The remainder of this memorandum addresses the disposition of projects in the face of decreased funding. Key factors in this discussion are presented subsequently.

HMO legislation authorizes three types of grants.

<u>Grant Type</u>	<u>Maximum Funding Authorization</u>	<u>Approximate Duration (Months)</u>
Feasibility	\$ 50,000	6-12
Planning	125,000	6-12
Initial Development	1,000,000	12-36

Further, legislation terminates grant fund authorizations as follows:

<u>Grant Type</u>	<u>Last Fiscal Year Of Current Fund Authorization</u>	<u>OMB Recommendation For Fund Authorizations</u>
Feasibility	76	77
Planning	76	77
Initial Development	77	78
Operational (Loan Fund)	78	79

The primary objective of the legislation is for HMO projects to become operational as qualified HMOs. Generally, projects must progress through three developmental stages (feasibility, planning, and initial development) before achieving operational status. The unique planning requirements of this process are summarized as follows:

1. Once started, a successful project needs increasing amounts of funds to progress from feasibility to planning to development.
2. New feasibility and planning projects must be started early to assure continuation of the program through the authorized duration.
3. Careful planning of the mix of grant types is required to bring the program to an orderly close without wasting Federal funds.

An idealized EMO program plan is presented in Tab A. This plan illustrates that the program is of discrete duration and requires funding levels which increase, peak, and then decrease. The increasing budget level for the first several years is required to accommodate the requirements of successful projects.

THE PROBLEM

Fiscal year 1975 funding resulted in grant awards of \$22.5 million and the following mix of approved grants:

<u>Grant Type</u>	<u>Number of Grants Active at End of FY 75</u>
Feasibility	104
Planning	22
Initial Development	28 (3 grantees at the initial development level are already operational)
	154

Legislative authorizations, budget levels used as the basis for program planning and fiscal year 1975 grant awards, and the President's budget are as follows:

<u>Fiscal Year</u>	<u>PL 93-222 Authorization</u>	<u>Grant Budget Amounts (Millions)</u>	
		<u>Planning Assumptions Used in Making FY 75 Funding Decisions</u>	<u>President's Budget</u>
1976	\$ 85	\$ 45	\$ 15
1977	85	65	18

Specific budget and program development problems include:

1. Fiscal year 1975 grant awards were made assuming grant budget levels of \$45 and \$65 million in fiscal years 1976 and 1977, respectively. Continuation of existing grantees into the next stage of development, with a normal attrition rate,* would require about \$30 million in fiscal year 1976. New starts would require the additional \$15 million.
2. The President's budget allows a total of only \$15 million for grants in fiscal year 1976. The OMB legislative recommendations for fiscal years 1977 and 1978 are \$18 million for each year.
3. Applications are now being received from existing grantees. Consequently, decisions concerning funding strategy should be made as soon as possible.
4. Demand from new applicants in fiscal year 1976 appears to be strong, yet planned budget amounts will allow minimal new starts only.

OPTIONS FOR PROGRAM ACTION IN FISCAL YEAR 1976

Three restructured program funding plans have been developed to provide a basis for the fiscal year funding decision. These plans are identified as follows:

1. Option 1 - Early Termination of Projects
2. Option 2 - "Stretch-out"
3. Option 3 - Added Funding from Reprogramming or a Supplemental Appropriation.

The funding options are based on updated regional and national level assessments of the probability of success for each currently funded project. Options 1 and 2 are consistent with the OMB plan for a 1-year program extension and flat funding levels of \$18 million for fiscal years 1977 and 1978. Option 3 provides for additional fiscal year 1976 funding, to be derived from either reprogramming of approved Public Health Services (PHS) funds or a supplemental appropriation. In addition, Option 3 is designed to ensure that out-years restore the program output to a level close to the output specified in earlier plans.

* For planning purposes, the following attrition rates were estimated:

Feasibility studies	25%
Planning	10%
Initial Development	10%

The Assistant Secretary for Health

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Options for program action are described in the following sections.

OPTION 1 - Early Termination of Projects

General Description: Under this option, the best of the existing projects would be selected for continuation and the remainder would be terminated in fiscal year 1976. Project selection would be determined by funding limitations for fiscal years 1976, 1977, and 1978.

As mentioned earlier, the Office for Health Maintenance Organizations has conducted a survey to estimate the success probability of each currently funded project. The major inputs of the survey were provided by HMO program staff in the Regional Offices. The probability of success for each project was assessed as Strong, Probable Success, Possible Success, or Probable Drop.

Estimates developed as a result of the survey are tentative. Some of the projects reviewed have been in progress for little more than a month, while others are more established. Furthermore, projects in the initial development stage can be assessed far more accurately than those in the feasibility stage. Nevertheless, the assessment resulting from the survey is the most objective possible at this time. Results are presented in Tab B, and are summarized below.

August 1975 Assessment of Success Probability for HMO Grantees

<u>Stage</u>	<u>Success Probability</u>			
	<u>Strong</u>	<u>Probable Success</u>	<u>Possible Success</u>	<u>Probable Drop</u>
Feasibility	10	32	35	27 (25%)
Planning	6	10	5	1 (5%)
Development	13	9	4	3 (10%)

Survey findings for the Probable Drop category coincide with the failure rates estimated in the current funding plan. If Option 1 were implemented, sixty-one projects beyond the estimated attrition rate would be terminated in fiscal year 1976. The remaining projects would be fully funded. Staff and contract support resources would be concentrated on the remaining projects to maximize their prospects for success.

Tab C describes Option 1 in depth. The following table summarizes the anticipated results of implementing this option in fiscal year 1976.

The Assistant Secretary for Health

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<u>Stage</u>	<u>Projects Eligible For Funding</u>	<u>Projects Funded</u>	<u>Average Funding Levels (Thousands)</u>	<u>Approved Funds (Millions)</u>	<u>Projects Terminated Beyond Estimated Attrition Rate</u>
Planning	77	21	\$ 125	\$ 2.6	56
Initial Development	21	16	700	<u>11.5</u>	<u>5</u>
				\$ 14.1	61

Funds remaining in fiscal year 1976 would be committed to 32 new starts at the feasibility level, thereby filling the "pipeline" for initial development in fiscal year 1977 and responding modestly to the demand for participation by new organizations. The attrition level of 61 projects to be terminated is based on a poll of Department Regional Offices and of professional and trade organizations in July 1975. Although results of the poll are incomplete, Tab D shows that more than 150 organizations intend to apply for funding.

Output Summary for Option 1

80 HMOs

\$ 74.2 million in grant funds

61 projects terminated beyond expected attrition in fiscal year 1976

OPTION 2 - "STRETCH-OUT"

General Description: Option 2 offers an alternative to early termination of projects, while maintaining compliance with the OMB marks. "Stretch-out" refers to funding projects at approximately half the authorized level, with the recognition that most of the projects would require an additional grant period to complete planning and developmental tasks. Extending achievement of the goal of operational status suggests that failure rates will increase. Under this option, however, no project would be terminated (beyond the expected attrition rate) in fiscal year 1976. Instead, terminations would occur at the planning and development levels in fiscal years 1977 and 1978.

As summarized below and presented in full in Tab E, implementing Option 2 in fiscal year 1976 would result in the termination of 42 planning and 3 initial development projects in fiscal years 1977 and 1978.

Option 2 - Fiscal Year 1976 Actions

<u>Stage</u>	<u>Projects Requiring Funding</u>	<u>Average Funding Levels (Thousands)</u>	<u>Approved Funds (Millions)</u>
Planning	77	\$ 62.5	\$ 4.9
Initial Development	20	490.0	<u>9.8</u>
			\$ 14.7

Compared to Option 1, Option 2 would accommodate a more limited number of new feasibility studies (10) in fiscal year 1976. These new grantees would be among the initial development projects in fiscal year 1978.

Output Summary for Option 2

77 HMOs

\$74.2 million in grant funds

45 projects terminated beyond expected attrition in
fiscal years 1977 and 1978

OPTION 3 - Added Funding from Reprogramming or a Supplemental Appropriation

General Description: The need to curtail Federal spending at this time is crucial. Nevertheless, this option is presented to provide a fair trial and assessment of the merits of HMO health care during the course of this program. Such an assessment is highly important in view of the key position assigned to HMOs in the major National Health Insurance proposals now being evaluated.

The increased funding is needed to expand program output, thereby providing a sounder base for assessment as well as an equitable response to the demand for participation in the program. The following factors must be considered in making a decision to provide added funding.

1. Sufficient numbers and diversity of projects evaluated to ensure comparison. At a minimum, a set must include eight projects of the following types:

- . Group vs. IPA
- . Urban vs. rural
- . Provider-sponsored vs. community-sponsored

Generally, two sets per region, or 160 HMOs, would provide an adequate basis for effective comparisons. The recommended evaluation level approaches the output of 170 HMOs, accepted by Messrs. Carlucci and O'Neill in January 1974, as an adequate basis for program evaluation.

2. Equitable treatment of current grantees, many of which would be terminated under Options 1 and 2 in spite of meeting criteria for advancement. (See Tab B)
3. Demands for participation by well-qualified organizations which have held back until full study could be made of their obligations under the Act and potential advantages to them (see Tab D).

The consequence of responsiveness to the preceeding factors is indicated below for fiscal year 1976 and described in full in Tab F.

Continuations (Full Funding)

<u>Stage</u>	<u>Projects to be Funded</u>	<u>Funding Level (Millions)</u>
Planning	77 projects	\$ 9.6
Development	20 projects	<u>16.0</u>
		\$ 25.6

New Projects. Funding all of the more than 150 potential applicants identified to date is not consistent with the concept of the program as a demonstration and is not recommended. Nevertheless, the validity of the demonstration would be enhanced by the addition of a number of applicants to the program roster. If funds can be identified, the following mix of projects is recommended for new starts in fiscal year 1976.

<u>Stage</u>	<u>Projects to be Funded</u>	<u>Funding Level (Millions)</u>
Feasibility	40 projects	\$ 2.0
Planning	10 projects	1.25
Development	10 projects	<u>8.0</u>
		\$ 11.25

Summation

<u>Project Type</u>	<u>Funding Level (Millions)</u>
Continuations	\$ 25.6
New Projects	\$ <u>11.3</u>
Total Funds Needed	\$ 36.9
Less FY 76 Budget*	\$ <u>15.7</u>
New Funds Needed	\$ 21.2

*Includes \$0.7 million "rural carryover" from FY 75

Output Summary for Option 3

142 HMOs

\$ 141.8 million in grant funds

No projects terminated beyond expected attrition rate

DISCUSSION

Pending Congressional action regarding the fiscal year 1976 Labor/HEW appropriation and the HMO Amendments of 1975, the three options described above represent the realistic range for HMO program actions during fiscal year 1976. Each option provides a responsible approach to program implementation. Therefore, advantages and disadvantages described in this section deserve serious consideration. Prompt selection of one option is needed because applications for continued funding are in hand or are forthcoming in September.

OPTION 1 - Early Termination of ProjectsPro

Complies with President's Budget for FY 76 and with OMB marks for out years

Con

Terminates 61 projects in FY 76 which are expected to meet program criteria and which would otherwise have progressed to operational status as qualified HMOs

Pro

- . Concentrates funding and technical assistance resources on the most promising projects
- . Does not "drag out" projects destined for later termination

Con

- . Will diminish the credibility of the Federal HMO program
- . Will cause substantial political problems with respect to terminated projects
- . Will provide only a bare minimum of projects for evaluation
- . Will reduce the magnitude of cost containment to be achieved when the HMOs become operational, compared to the level of cost containment resulting from Option 3

OPTION 2 - "Stretch-Out"Pro

- . Complies with President's Budget for FY 76 and with OMB marks for the out years
- . Maintains projects in the "pipeline," in the event that added funding materializes later
- . Dilutes political reaction by deferring FY 76 terminations and spreading them over FY 77 and FY 78

Con

- . Penalizes both strong and marginal projects by reducing available resources
- . Increases the probability of failure through loss of sponsor and community enthusiasm as the goal of operations status becomes more distant
- . Reduces funding and technical assistance resources available per project compared to Option 1
- . Will diminish the credibility of the Federal HMO program
- . Will provide only a bare minimum of projects for evaluation
- . "Drags out" projects destined for termination later
- . Will reduce the magnitude of cost containment to be achieved when HMOs become operational, compared to the level of cost containment resulting from Option 3

OPTION 3 - Added Funding from Reprogramming or a Supplemental AppropriationPro

- . Produces sufficient HMOs for an adequate trial and assessment of the HMO concept
- . Permits support of all projects funded in FY 75 and in compliance with advancement criteria
- . Permits substantial new participation by qualified applicants in FY 76
- . Enhances the credibility of the Federal HMO program, thereby promoting private development
- . Doubles the potential for cost containment through operational HMOs, compared to Options 1 and 2

Con

- . Exceeds President's budget for FY 76 and OMB marks for the out year
- . Requires reprogramming of approved PHS funds or successful request for a supplemental appropriation

RECOMMENDATIONS

1. Initiate renewed efforts to secure Administration and Congressional approval for the additional funds needed to implement Option 3.
2. Implement Option 2 only if success in gaining added funds is probable, thereby facilitating a transition to Option 3.
3. Implement Option 1 if approval to increase program funding cannot be obtained.

Robert van Hoek, M.D.

Enclosures:

- Tab A - Idealized HMO Program Plan
- Tab B - Estimate of Success Potential for HMO Projects Funded in FY 75
- Tab C - Early Termination Approach to an HMO Funding Plan
- Tab D - Prospects for Participation in HMO Program in FY 76
- Tab E - "Stretch-out" Approach to an HMO Funding Plan
- Tab F - Added Funds Approach to an HMO Funding Plan

CONCURRENCES

OAM/PHS, DROKE: Concur _____ Nonconcur _____ Date _____

DECISION

1. That action be taken to identify and obtain additional funds for the HMO program in order to implement Option 3.

Approved _____ Disapproved _____ Date _____

2. That Option 2 be implemented, pending identification of additional funds required to make the transition to Option 3.

Approved _____ Disapproved _____ Date _____

3. That Option 1 be implemented.

Approved _____ Disapproved _____ Date _____

4. That Option 2 be implemented.

Approved _____ Disapproved _____ Date _____

Prepared by: HSA, SEUBOLD, 8/28/75, x34106

HSA Contact: SEUBOLD, x34106

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
Bureau of Community Health Services

TO : Director

DATE: October 1, 1975

FROM : Associate Bureau Director, HMO

SUBJECT: Proposed HMO Funding Plan for Fiscal Year 1976

The draft proposed plan dated September 19, previously submitted to you for review, was discussed in detail with the Regional HMO Staff in Rockville on September 24-25. A number of constructive recommendations were made and are incorporated in this revised plan. The process described below will implement Funding Option 1, as directed by the Administrator, with minor modification to ~~reflect~~ the actual funding requirements of initial development projects.

The major features of the plan and process are:

- ①. Funding must stay within the limits of anticipated program funds and duration
 - FY 1976 - \$15.7 million
 - FY 1977 - \$18.0 million
 - FY 1978 - \$18.0 million (development projects only).
 - FY 1979 - loans, loan guarantees only.
2. Projects should be funded fully, after careful review to substantiate the real need for all projected expenditures, in order to maximize prospects for success.
3. Regional priorities will be updated on a monthly basis, using quantitative objective scoring, in order to be responsive to changes in project status, so that funding decisions will reflect the current relative merits of the candidates as accurately as possible. The process is designed to assure that adequate funds remain available for top-rated projects throughout the year.

Regional project ratings, scored according to the methodology described in Tab A, are to be delivered to Rockville by October 3. A meeting with Regional Program Consultants is scheduled for October 8 at O'Hare Airport to review the national ratings and arrive at the initial set of funding priorities. As noted above, these will be updated monthly as a basis for funding decisions.

Director

2

Range of Funding Possibilities for Fiscal Year 1976

A variety of possibilities exists for the fiscal year 1976 funding pattern depending on the number of projects deemed acceptable for advancement to initial development status, the practice mix (GP or IPA) of those projects, and the extent to which they can be ready for advancement before the end of the fiscal year. In each instance, the output can be compatible with the projected out-year funding. Examples of possible patterns are given in Tab B. In summary the following ranges are feasible:

Feasibility: 40 - 32 projects
Planning: 40 - 27 projects
Development: 16 - 18 projects

These estimates assume full authorized funding at the feasibility and planning levels and averages observed to date for initial development projects of the two major types: group practice at \$700K and IPA at \$400K.

Subject to refinement of positions at the October 8 meeting, it appears likely that 16 of the current 22 planning projects will merit advancement to the initial development level. Eleven are group practice type and five are IPAs. In order to maximize the output from fiscal year 1975 feasibility efforts, it appears wise to limit funding of new feasibility projects in fiscal year 1976 to 32, 16 in each cycle. Depending upon the time in the fiscal year at which high priority feasibility projects would be advanced into the planning stages, 32 to 40 such projects could be funded. That is, if they come up late in the year, some may not be ready for initial development funding until early fiscal year 1978 rather than late fiscal year 1977.

The plan can be made sufficiently flexible to accommodate some fiscal year 1977 funding at the initial development level of fiscal year 1975 planning projects started late in that fiscal year. Under such circumstances, it would be possible to initiate a limited number of new initial development or expansion activities in fiscal year 1976.

In any event, the process would be the same, with the funding decisions being made on the basis of top choices from the priority list prepared with the assistance of Regional Office staff.

Funding Decision Process

1. Currently Funded Initial Development Projects

- a. It is expected that these will complete their activities within the funding already awarded so that no additional grant funds will be required.

- b. Advancement of these projects into operational status will be handled as usual. Particular care should be directed toward preparation of fully-responsive qualification and loan applications in order to assure prompt transition into operational status.

2. Currently Funded Planning and Feasibility Projects

- a. Regional Office staff is to score projects separately in each category (see Tab A for methodology) and rank them in priority order by October 3.
- b. It appears probable that all of the currently active planning projects that will be deemed acceptable can be funded. These, therefore, will be reviewed and judged as a unit without special consideration as to Regional distribution.
- c. The first two choices among feasibility projects in each Region, subject to approval by the ABD, HMO, will be funded. The remaining selections will be made by the OHMO Executive Committee on a national basis with guidance from the Regional Program Consultants at a joint meeting on October 8.
- d. Statutory priorities will be addressed at this point by making any changes necessary to assure that:
 - 1. 20% of the projects are those which will serve non-metropolitan areas, provided that there are a sufficient number of such projects which meet the overriding criterion of fiscal viability; and
 - 2. other factors being equal, preference is given to those projects which provide assurance that they will serve populations from medically-underserved areas.
- e. The priority order arrived at will be updated on a monthly basis, with substantiated ratings to be sent by each Region by the last working day of each month. The update is to reflect significant changes in project prospects for success based on both internal progress and external factors.
- f. As applications are received, they are to be evaluated by standard review procedures. If the project ranks among the top Regional and national priority listings to the extent that such funds are available, and if all necessary criteria have been met, the project will be funded.

- g. If a project meets the necessary criteria, but is not within the top ranking, the grantee is to be informed that the application is acceptable but cannot be funded because of budget limitations. The grantee should be given an explanation of the funding strategy and the assignment of priorities so that the reason for denial of funding will be understood.
- h. Projects which do not meet the criteria will, as usual, be so informed.
- i. In all cases, a full report of the feasibility study is needed to document the factors leading to the determination.

3. New Projects

- a. It has been deemed appropriate to fund new feasibility projects in fiscal year 1976.
- b. In order not to overload the system in fiscal years 1977 and 1978, not more than the equivalent of 32 new feasibility projects will be funded in fiscal year 1976. Applicants will be evaluated as in the past according to the Objective Review Process and classified as "rejected" or "approved." Each Region will score and priority-rank its "approved" applicants. As in the case of the continuation projects, the first priority of each Region will be funded in each of the two grant rounds with the concurrence of the ABD, HMO. The remaining six projects to be funded in each round will be selected on a national basis by the HMO Executive Committee with guidance from the Regional Program Consultants.
- c. Approved but unfunded projects from the first fiscal year 1976 grant round are to be notified that they will be considered in competition with the second round applicants, if they so desire.
- d. Applicants for grants for expansion will not be considered. Loan support is an appropriate source of assistance for operating costs attributable to significant expansion. This requirement limits the field to qualified HMOs which have a source of revenue and therefore the potential for repayment.

Conclusion

The proposed plan is advanced as the most equitable and most productive possible in view of the limited funding available in fiscal year 1976.

Director

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It will provide for a minimum of four funded projects per Region plus those that advance into initial development and operational status plus any that apply for and receive loan support for expansion. The minimum output is projected to be 80 operational HMOs by the end of the authorized program duration.



Frank H. Seubold, Ph.D.

Enclosures:

Tab A - Project Scoring Methodology

Tab B - Range of Funding Possibilities for HMO Program in FY '76

TAB APROJECT SCORING METHODOLOGY

<u>FACTOR</u>		<u>Scoring Range</u>			
1.	<u>Grantee commitment</u> , as clearly demonstrated by tangible contributions, money being the most tangible.	0	1	2	3
2.	<u>Provider Commitment</u> A. Provider sponsored - commitment clearly evident through sponsorship by individual physician organization, medical group, or signed agreements to provide service-not merely general expressions of interest. B. Consumer sponsored - letters of support and/or interest by physicians, interest by medical schools to participate in Plan development, interest of hospitals or other provider institutions to participate (higher scores where letters of agreement and/or contracts are signed.)	0	1	2	3
3.	<u>Staff Competence</u> to develop and organize an HMO, as shown by track record either on the project or in previous employment.	0	1	2	3
4.	<u>Market potential</u> , in terms of employer, union, State resources and willingness to undertake contracts; purchasing power; project Board of Directors composition; marketing strategy, if developed; competitive situation; potential for fiscal viability.	0	1	2	3 4
5.	<u>Legal situation in State</u> , including any Certificate of Need or reserve requirement problems.	0	1		

Notes:

Maximum Score: 12

Any three "0" scores is an automatic washout.

This scoring methodology is in addition to the normal review process which consists of review standards, site visit reports, outside consultants, quarterly progress reports, track record of grant and milestone progress, etc. For this selection a summary review pink sheet will be completed with strengths and weaknesses, scores, and other grantee information.

TAB B

RANGE OF FUNDING POSSIBILITIES FOR THE HMO PROGRAM IN FY 1976

		<u>'75</u>		<u>'76</u>		<u>'77</u>		<u>'78</u>		<u>'79</u>
1. F	104	5.2	32	1.6	-	-	-	-	-	-
P	22	3.8	27	3.3	24	3.0	-	-	-	-
D	28	<u>13.5</u>	18	<u>10.8</u>	25	<u>15.0</u>	30*	<u>18.0</u>	-	<u>-</u>
		22.5		15.7		18.0		18.0		-
O	4		25		16		23		27	

* includes 8 new development or expansion projects

		<u>'75</u>		<u>'76</u>		<u>'77</u>		<u>'78</u>		<u>'79</u>
2. F	104	5.2	32	1.6	-	-	-	-	-	-
P	22	3.8	36	4.5	24	3.0	-	-	-	-
D	28	<u>13.5</u>	16	<u>9.6</u>	25	<u>15.0</u>	30*	<u>18.0</u>	-	<u>-</u>
		22.5		15.7		18.0		18.0		-
O	4		25		14		23		27	

* includes 8 late projects from FY '76 planning and 22 projects from FY '77 planning

		<u>'75</u>		<u>'76</u>		<u>'77</u>		<u>'78</u>		<u>'79</u>
3. F	104	5.2	32	1.6	-	-	-	-	-	-
P	22	3.8	40	5.0	24	3.0	-	-	-	-
D	28	<u>13.5</u>	15	<u>9.1</u>	25**	<u>15.0</u>	33**	<u>18.0</u>	-	<u>-</u>
		22.5		15.7		18.0		18.0		-
O	4		25		13		23		30	

* 24 from FY '76 planning and 1 from FY '75 planning

** 22 from FY '77 planning and 11 from FY '76 planning

		<u>'75</u>		<u>'76</u>		<u>'77</u>		<u>'78</u>		<u>'79</u>
4.	F	104	5.2	40	2.0	-	-	-	-	-
	P	22	3.8	32	4.0	30	3.8	-	-	-
	D	28	<u>13.5</u>	16	<u>9.7</u>	24	<u>14.2</u>	32*	<u>18.0</u>	-
	O	4		25		14		22		29

* 5 from FY '76 planning and 27 from FY '77 planning

Senator KENNEDY. I just want to say it has been very, very helpful to get these comments of yours and your testimony. I think it has been enormously useful and valuable to us on the committee.

And, I just want to commend you and assure you that I know you have spent a great deal of time in reviewing this and that you have put a good deal of effort into it. And, it showed from your study of it and from your response to the questions.

It will be very helpful to us in trying to do something that is important in this area. So we want to thank you very much.

Mr. MARTIN. Thank you.

Senator KENNEDY. It is really a very fine job.

Our next witness is Dr. Cooper, Assistant Secretary for HEW, accompanied by Jim Dickson, Robert Van Hoek, Frank Seubold, and Dale Sopper.

Dr. Cooper, good morning. We are glad to have you here. We look forward to your testimony. We might get into some of the questions early. Senator Pell is going to Chair at 11 so we will have a chance to—

STATEMENT OF THEODORE COOPER, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY JAMES F. DICKSON III, M.D., ACTING DEPUTY ASSISTANT SECRETARY FOR HEALTH, DHEW; ROBERT VAN HOEK, M.D., ACTING ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION, DHEW; FRANK SEUBOLD, PH. D., ASSOCIATE BUREAU DIRECTOR, HEALTH MAINTENANCE ORGANIZATIONS, HEALTH SERVICES ADMINISTRATION, DHEW; AND DALE W. SOPPER, ACTING DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DHEW

Dr. COOPER. In the interest of time and getting down to the gut issues, I would like, with your permission, to submit my statement and charts in their entirety for the record.

Senator KENNEDY. We will include it in the record at the conclusion of your testimony.

Dr. COOPER. I would also say, it was very helpful to me to listen to a good part of your questioning of the GAO, and their constructive criticism of the program and its evaluation.

And I think it would be worthwhile to—

Senator KENNEDY. I hope they can stay and listen to you. I should have asked them. It's a two-way street, you know.

Dr. COOPER. I know. We looked forward to the opportunity to discuss with them their evaluation because, as you know, although it is such—

Senator KENNEDY. Well, he is here. Mr. Schulz, can you stay with us for a little while?

Mr. SCHULZ. Sure.

Senator KENNEDY. Good.

Dr. COOPER. Obviously, we have some difference of opinion as to how some of the actual factual material is interpreted. I think there is no need to debate the importance of the program.

I want to make clear at the outset my commitment and the Secretary's commitment in making this an effective program. And, despite the concerns and the justified criticisms from time to time about our deficiencies in implementing the program, I want to make it absolutely clear that we have a commitment to try to make this work and we shall do so.

There have been a lot of issues that have been raised about the satisfaction with the program and I would like to comment on that first, if I may.

We have restructured the program's administration and management to a single operational entity. I would comment also, since it was raised recently, about the regional program. I am currently reviewing the structure of the service that is given to the applicants in the region and its relationship with the headquarters' staff, in this regard.

I believe the regional operation can help service the people in this regard and the pros, here, outweigh the cons. I will see to it, and I have already indicated to my staff that I will put additional people and additional consultants out there to do this within the context of our current ceilings on position.

Now, we have had a great deal of delay—some of which was necessary discussion with labor and so on about some of the regulations. We will, again, try to expedite the regulations process.

I have recently talked with the General Counsel about the timetable and completing the regulations process, and we have his commitment as well as my own to try to expedite the promulgation of outstanding regulations by January and March, as well as all the guidelines that are necessary for implementing the regulations.

I have had substantial discussion with the General Counsel and recognize his problem in staffing. This is not a program staffing consideration, as has been explained. The General Counsel staff comes from the Office of the Secretary overhead, and we would support the Office of the Secretary having the necessary staff needed to do this.

Senator KENNEDY. Does this mean they are going to make a request for more?

Dr. COOPER. I cannot speak for the Secretary in that regard, Senator, but the General Counsel's office, although we have pressed them on several pieces of other legislation that require regulations for implementation, will recognize our priority for this particular program.

Senator KENNEDY. Well, they will have my support for it, if they make that request.

Dr. COOPER. Now, the Department has published a great number of the regulations that were needed, including those that service medic-aid.

I recognize the situation here in which the rate of intention for the qualifications process has been stepped up. We have allocated additional positions; but in conformance with the civil service requirements, the selection of the candidates for filling those positions has not been completed.

In the interim, I have asked the staff and my executive officers to make available within the ceilings available to the Public Health Service at this time to put any necessary people on detail, to expedite the review process and make it as current as possible.

I think I should make clear that if an application is absolutely first class and complete, that process takes about 2 weeks, and it has been accomplished in that time frame. On the other hand, the average experience is that the iterative process, if we had adequate staff assigned to it, requires about 60 man-days.

The average is running, currently, about 84 man-days, reflecting the deficiencies of the applications themselves.

In order to address that administratively, we will fill the positions. I will give priority to allocation of other positions to the program permanently, as we get caught up. In the meantime, I have asked Dr. Van Hoek, the Acting Administrator of HSA and my executive officer to seek whatever additional people are necessary on detail to catch up the backlog so that we do not impede this progress.

I do recognize that in certain States, for example, the concomitant review and fairness of dealing with this qualification process is essential to the competitive position of various programs for dealing with the working public and I think we shall do that.

With respect to the applications process, which is a separate question, I would like to comment on some of the discussion that has already been had with the GAO and I think we have to distinguish what our intention is under the budgetary constraints with respect to stopping ongoing programs that are successful. We have no intention of terminating support for programs that are serving people.

The analysis on option 1 and so on that was described had to do with feasibility studies and planning grants in that given stage. I would make the commitment to you now that in that process, if there are meritorious projects ongoing and if the funds allocated either by the Congress through the appropriation or our own request are insufficient, I would seek personally for a way by either reprogramming within that authority or transfer within other authorities still within the limit of the President's request, to find those funds necessary to keep those projects viable and, in addition, to fund additional new projects.

Now, the reason I say that—and I am confident that that is possible—is because last year, as you know, I reprogrammed \$11.4 million out of that account because we did not have enough suitable applications. And I will deal with that directly if the situation warrants.

Now, that was not in option 1. GAO had no opportunity to review my evaluation to that in the recent budget review process. First, I want to make clear that we have no intention of stopping ongoing service programs to people—and in a sense, that might have been implied in that discussion. And second, I am not interested in stopping meritorious projects of any kind if they are in the national interest and service the people, and would put it at priority to accomplish that re-financing provision.

Senator KENNEDY. Well, let me tell you, these comments, I think, are enormously encouraging. They are to me and I think they should be to all of us.

What does that mean then, Mr. Secretary? Does that mean that if programs are meritorious and are providing important needs that they will not be terminated or eliminated if the moneys that are necessary for their continuation are Federal funds?

Dr. COOPER. Yes. The Federal portion of it; yes, sir.

And I think that you have to keep in mind also that we have not yet received our 1976 appropriation.

Senator KENNEDY. That is right.

Dr. COOPER. And the reflection of the concern about what this program promises is also reflected in the Appropriations Committee's actions thus far. You will note that in both the House action and in the Senate action they did not add on to the administration's request either.

But, if this is necessary, in my opinion, for me to consider going back to the committees and to this committee, I would certainly do that under those conditions.

Senator KENNEDY. I went down to the Appropriations Committee myself and asked for additional funds, but it is tough to argue against the fact that they had not spent the moneys that were left from last year.

Dr. COOPER. That is correct. And I recognize that.

Senator KENNEDY. So, many of us who were strongly committed toward trying to see the implementation are battling against that particular fact.

Dr. COOPER. And I certainly would consider, as I said, we did reprogram funds out because they were not utilized last time. I would be just as receptive, particularly to save on-going meritorious projects, to reprogram back in.

Senator KENNEDY. Well, that is helpful. I must say when we were facing the cutbacks of the possible termination of programs in neighborhood health centers and some of the community mental health centers, too, they did some reprogramming to maintain existing programs. I think that is an absolutely essential aspect of the item.

Dr. COOPER. Even within our total PHS appropriation I would also be willing to recommend that which is warranted—transfers and the reprogramming being within an authorization, but even transfers between different authorizations even within the same appropriation level.

Senator KENNEDY. Well, let me ask you this, Doctor, if we went through these changes, which would make it more easy for additional applications to come on in, given the backlog you are even facing now on it, how will you—from an administrative point of view—consider those?

Dr. COOPER. You mean the backlog developing on the qualifications process?

Senator KENNEDY. It will be, perhaps, more attractive and interesting to a lot more groups. And, I would think there would be many more looking after still a relatively small pot of resources. And, I would think that if you have got the administrative problem at the present time, you'd be inundated with additional applications.

Dr. COOPER. Well, I think there are two different problems here. Some of those are not seeking the kind of grant funds for feasibility planning in that sort of operation. And, in that sense, the backlog that we have to be concerned about in the qualifications process is to be sure that the communities can react to the opportunity to offer the programs to their citizens or to the employees of a given institution.

I do not think that would be an administrative barrier. What I want to eliminate from our administrative standpoint is the likeli-

hood that we have to tell people that it might take up to 4 months before we can get to them.

In discussing this with the staff, as I indicated, I am reluctant to make it a policy to discourage people from coming in if we can deal with it. And the way I expect to deal with it is to put more people on the job—seek out through appropriate mechanisms, within the civil service guidelines, permanent personnel—but expedite as much as I can the recruitment as well as the detail of people to get this job done.

Senator SCHWEIKER. On the personnel level, Mr. Secretary, OMB always play a tremendous role: I found in our Health Appropriations Subcommittee that OMB impounds jobs, and subverts what we try to do with authorizing legislation.

While I don't expect you to comment on that, I would ask you if it would be helpful for our legislation to specify types and number of personnel so that you are sure that you have it regardless of what the OMB ceiling is?

Dr. COOPER. No, sir. I honestly do not think that would be helpful. I think what I need to have is the flexibility to utilize the resources I have in the way that I can expedite the action of programs.

Senator SCHWEIKER. Well, will OMB give you that flexibility?

Dr. COOPER. Well, I think that—

Senator SCHWEIKER. Judged on past performance, you are a little more optimistic than I am about it.

Dr. COOPER. Let me say, for example, in reading the Senate report on appropriations, where we are directed to reduce the office of the Assistant Secretary overhead by \$2.3 million, I am preparing now to reduce the office of the Assistant Secretary staff 150 positions.

That kind of instruction is not terribly helpful in trying to implement some of the programs that you are insisting on the one hand that in my office I retain surveillance of. Nevertheless, a blanket instruction like that is much more helpful than a line-by-line indication because, in good faith, I think there are methods that I am willing to employ to redistribute resources to meet priority needs if the administration and the Congress decide this is what the health share of the pie should be.

As a manager and from the management standpoint, I would urge, not only OMB but the Congress, not to write in line by line things that reduce my flexibility to respond to the kind of backlog crises and things that we are talking about at this time.

Senator KENNEDY. Doctor, how are you going to be able to really determine the quality of HMO's in these employer packages?

Dr. COOPER. Well, there are two processes. And what I interpreted about what the intent was in the original law of asking that in the office of the Assistant Secretary there be kept a capability for insuring the quality here, is that, the certifying process ought to be separate from the operations of the enthusiasts who are trying to build these programs in order to avoid a conflict of interest. And I endorse that separation.

Operationally, from the standpoint of what I just mentioned to Senator Schweiker about how you actually can do resource allocation within a given situation, I intend to try to supervise that in two ways: first, to distinguish the certifying office within the Office of the Administrator, which is my direct liaison with that; and second, within my

office I have recently received approval from the Secretary to have all the quality assurance supervision under a Deputy Assistant Secretary.

And, within that structure, I intend to have the supervision but not the operation for the quality assurance activities called PSRO, long-term care, and HMO operations. I am currently recruiting to get that position filled and to complete restructuring the setup as the appropriate staff office.

We have already, in the absence of that, taken directly the responsibility of supervising Dr. Van Hoek and Dr. Seubold.

And, if you would like, I would give you a package of exchanges that we have had that dealt with specific issues of subcontracting and its quality, interest rates, loan rates, and so on that we have directly involved ourselves in as I interpreted was the original intent of the original congressional insurance of quality from my office.

Senator KENNEDY. Well, could you make that available to us?

Dr. COOPER. Yes. We will make it available.

[The material requested follows:]

Acting Administrator/HSA/PHS

NOV 18 1973

Director
Office of Administrative Management

Interest Rates for Health Maintenance Organization Loans and Loan
Guarantees

This office concurs in the policy outlined in your memorandum of November 11 for establishing the basis for interest rates on both direct loans and loan guarantees under the Health Maintenance Organization Program.

To assist in implementation of the approved policy, this office will provide the rates on outstanding marketable obligations of the United States for 20-year maturities to the Loan Accounting and Fund Section, Fiscal Branch/HSA on a recurring basis. That office should provide the appropriate interest rate for each direct loan or loan guarantee to the program office on the date of each loan commitment. Such rates shall be available to the applicant for a period of 90 days, only, in accordance with the terms of the agreement. Should it become necessary to extend the agreement beyond 90 days, the interest rate must be recalculated, based on the prevailing rate on the date of such extension.


John C. Droke

cc:

Mr. Dave Benor, Pkln- Rm. 4A-53
Mr. Bill Stanley, Pkln. Rm. 16-05
✓ Mr. Robert Schaeffer, Pkln. Rm. 6A-37
Dr. Frank Seubold, Pkln. Rm. 7-39

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Director
Office of Administrative Management

NOV 11 1975

Acting Administrator

Interest Rates for Health Maintenance Organization Loans and
Loan Guarantees

To respond definitively to your memorandum of November 4, I wish to reflect the results of discussion among my staff, the Loan Policy Officer of your office, and the Office of General Counsel.

The following formal policy is proposed in setting interest rates for both loan guarantees and direct loans:

1. The Secretary will guarantee an interest rate which does not exceed one percent (1%) above the prime commercial interest rate at the time of loan guarantee commitment. Provided, however, that the interest rate for any loan guaranteed by the Secretary to a non-Federal lender shall not exceed one percent greater than the interest rate for marketable obligations of the U.S. Treasury for 20 year maturities.
2. Such prime rate will be determined by reviewing the rates of Chase Manhattan, First National City Bank of New York, and the Bank of America. If any two rates are the same, such rate shall govern. If all three are different, the average rate, to the nearest one-tenth of one percent, will be governing. This will allow the rate to reflect national commercial rates, both New York and West Coast.
3. The interest rate for direct loans shall be the same as for loans guaranteed to non-Federal lenders.

We have already issued loan agreements to three projects for which closings have not yet occurred. These agreements state that the interest rate will be established at time of endorsement. In order to permit time for preparation of loan closing documents, it is recommended that the interest rate be established, in accordance with the above policy, three working days before each endorsement.

FILE
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OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
CAB	Parkins	11/11	CH	Benson	11/11/75			
LEPH	Quinn	11/11	BEHS	Martin	11/11/75			
LEPH	Levine	11/11/75						

Director, Office of Administrative Management

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I would appreciate your early concurrence in view of the loan closings scheduled on November 13 and 18.

John E. Marshall
for Robert van Hoek, M.D.

BCHS:DOD:RLSchaeffer:jsc 11/11/75

cc: ES/H; HSA/ES; BCHS/OD; DOD/O.F.; DOD/R.F.

Edward D. Martin, M.D.

Frank H. Seubold, Ph.D.

Dave Benor, OBC

Loren Spiva, Loan Policy Officer, H

William Stanley

Robert L. Schaeffer

Donald M. Perkins

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Acting Administrator/HSA/PHS

DATE: NOV 4 1975

FROM : Director
Office of Administrative Management

SUBJECT: Interest Rates for Health Maintenance Organization Loans and Loan Guarantees

Subsection 1308(b)(2)(D) of the Health Maintenance Organization Act states that direct loans made to Health Maintenance Organizations (HMOs) shall...."bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to loans guaranteed under this title." During the early stages of implementation of this program, it was recognized that it would be necessary to approve direct loans prior to the approval of loan guarantees and that a problem would be encountered in compliance with this section of the Act. Therefore, it was determined that a rate of interest would be charged for direct loans, based on Treasury obligations with similar maturities, plus administrative fees charged by the Federal Financing Bank (FFB). It was recognized that this procedure would entail limiting the interest rate on loan guarantees to a rate which would be comparable to the direct loans.

Strict compliance with the requirements of the portion of the Act cited above will impose a hardship on either those applicants applying for loan guarantees or those applying for direct loans. In recognition of this, the Committee on Interstate and Foreign Commerce proposed to amend the Act to permit the Secretary to establish separate interest rates for direct loans and loan guarantees, as indicated in H.R. 9019. However, in expressing the Department's views on H.R. 9019, the Secretary, by letter of September 10, indicated that he could not support this amendment and stated that the interest rate on direct loans to HMOs should continue to be set, as in present law, at the rate at which HMOs obtain guaranteed loans in the market place.

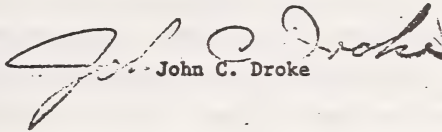
In view of the above, we have no choice but to withdraw the interest rate of 8 5/8 percent provided to you on October 1 and intended for your use until new rates are received from the Treasury in November. Pending resolution of this interest rate issue by the Congress, Treasury rates will not be provided for your use by this office and it is suggested that interim procedures be established for determining appropriate interest rates for HMOs which are in compliance with the Act and the views expressed by the Secretary. Since there have been no loans guaranteed under this title, you may wish to consider utilizing the experience gained with regard to guaranteed loans in other PHS programs, such as the

Acting Administrator/HSA/PHS

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Hill-Burton Loan program, with appropriate consideration for variations in maturities.

We are very much aware of the problems which may be encountered in your efforts to comply with the current requirements of the Act. However, a basis for determining interest rates must be established in compliance with the Act and be applied uniformly on all future direct loans. Such basis should be approved by both this office and the office of the Assistant General Counsel for Public Health. We will be pleased to work with members of your staff in developing an appropriate basis if you so desire.



John C. Droke

cc/
✓ Robert Schaeffer

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
OFFICE OF THE ADMINISTRATOR

TO : Acting Director
Bureau of Community Health Services

DATE: OCT 31 1975

FROM : Acting Associate Administrator for Management

SUBJECT: Management of Loan Programs

Transmitted herewith for your information and guidance is a copy of a memorandum from the Director, Office of Administrative Management, PHS, in reference to the management of activity in the Health Maintenance Organization (HMO) loan and loan guarantee program.

As noted in the last paragraph of the enclosed memorandum, personnel of the Loan Accounting and Fund Section should participate in discussions and meetings as may be required for the purposes as stated.



William H. Appden, Jr.

Enclosure

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health ServiceTO : Acting Administrator *RJA* (c) 4
Health Services Administration/PHS

DATE: OCT 6 1975

FROM : Director
Office of Administrative Management

SUBJECT: Management of Loan Programs

At the August 15 Policy Board meeting, both you and Dr. Endicott commented on the current method of managing the various loan programs in PHS. As a result, I was requested to review the situation and, by memorandum of September 10 (Tab A) presented several recommendations to the Assistant Secretary for Health. As you will note, he has concurred in these recommendations.

While it has been determined that the loan and loan guarantee functions should not be separated from the basic program responsibilities, it is vital that qualified personnel be recruited and trained to properly manage the loan programs. Further, detailed operating procedures and guidelines must be developed to assure that loans and loan guarantees will be managed in a uniform and consistent manner.

It is apparent that most of the activity in the Health Maintenance Organization (HMO) loan and loan guarantee program will be in the nature of direct loans. Therefore, it is particularly important that all loan instruments comply with the uniform provisions necessary to permit batching and resale of such loans to the Federal Financing Bank (FFB). Having recognized the necessity for such uniformity, this office provided prototype documents to be utilized in the closing of HMO loans and such documents were reviewed and approved by the Office of the Assistant General Counsel for Public Health. Under no circumstances should these prototype documents be revised without the express written approval of this office and the Office of the Assistant General Counsel for Public Health. Further, program personnel should be instructed that commitments, either verbal or written, shall not be made to potential loan recipients which are contradictory to the provisions contained in these instruments or which are contrary to the financial interest of the United States, the appropriate statute, regulations and policies promulgated and approved for this program.

Acting Administrator
Health Services Administration/PHS

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This office has agreed to provide marketing services for the HMO loan program. However, we do not have the staff necessary to either review all loan closing instruments or to assist in the actual loan closing process. Therefore, we are dependent upon the review of all such documents by appropriate personnel in your Loan Accounting and Fund Section, Fiscal Branch, to assure compliance with the uniform provisions necessary to facilitate batching and marketing of HMO loans. In order for that office to carry out its responsibilities, it is imperative that members of that staff participate in discussions and meetings with program personnel which have a potential impact upon the financial interest of the United States or our relationship with the FFB.



John C. Droke

Enclosure

Tab A - Management of Loan Programs - INFORMATION

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health ServiceTO : The Assistant Secretary for Health
Through: ES/PHS _____

DATE: SEP 10 1975

FROM : Director
Office of Administrative ManagementSUBJECT: Management of Loan Programs - INFORMATIONPURPOSE

At the August 15 Policy Board meeting, Dr. Endicott and Dr. van Hoek commented on the current method of managing the Health Services Administration (HSA) and the Health Resources Administration (HRA) loan programs. A suggestion was made that we should consider a different organizational location for these programs, and I was requested to study the situation.

BACKGROUND

1. The Public Health Service (PHS) loan programs are the Medical Facilities loan and loan guarantee program in HRA and the Health Maintenance Organizations (HMOs) loan and loan guarantee program in HSA. The current and proposed available authorizations for these programs through this year amount to a minimum of \$2.7 billion. In addition, HRA has responsibility for administering teaching facilities construction and student loan programs. The total projected volume of teaching facilities construction loan guarantees is quite small and the student loan programs are generally different in nature since the actual loans are made by universities from loan funds awarded to them by HRA.

2. Loans and loan guarantees are considered another type of financial assistance similar to grants and contracts. While the awarding of loans is not in itself a program activity, the primary responsibility for the loan activity should be vested in the agency organizational unit that carries out the program responsibilities. We are concerned that several cases of improper administration within the loan programs have occurred because program officials have made commitments to recipient organizations which cannot legally be honored or are contrary to the best interests of the government.

TRACER2037

3. Proper administration of loan programs in PHS requires the same combination of program and loan management personnel with appropriate expertise at each level of management--program, agency, and Office of the Assistant Secretary for Health (OASH)--that we have developed over the years in the grant programs. In June 1974, we established a loan policy officer on my staff. A separate loan accounting unit to serve the HRA and HSA activities was also established in the Parklawn accounting office.

We have discussed the need for more qualified agency staff with the executive officers of HSA and HRA and, to date, it appears that little action has been taken to employ personnel at headquarters having specialized experience in the loan area. As a result, the OASH loan officer has become involved in many operational problems which should normally be processed by personnel at the program level. In my May 16 memorandum to Dr. Endicott, it was indicated that out of the positions made available for implementing the new National Health Planning and Resources Development Act, positions should be provided to implement and administer the loan and loan guarantee portion (Title XVI) of the act.

4. Earlier this year (May 9), a PHS Task Force was formed with participation of HSA and HRA to develop improved loan monitoring procedures. The monitoring of these loans involves both headquarters and regional office personnel, and this aspect of the loan function is assuming much greater importance since we have 229 loans outstanding and an additional 68 committed representing over \$1.1 billion in loans. When the task force began its work on June 5, HSA and HRA indicated that they would prefer to develop their own manuals and have them reviewed at the OASH level rather than to work as a group to develop a single manual. We agreed to their suggestions and are now awaiting the development of these monitoring procedural manuals by the agencies.

RECOMMENDATIONS

In summary, I believe we should encourage HRA and HSA to accept the following principles.

1. The loan and loan guarantee functions should not be separated from the other basic program responsibilities of the HMO and Medical Facilities programs.
2. The use of loans and loan guarantees is another mechanism of financial support and as such conceptually should not organizationally be treated significantly different from the way we have organized grant and contract responsibilities at the various program and staff levels in the Public Health Service.

The Assistant Secretary for Health

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3. The most pressing need at this time is to recruit and train qualified personnel at the program level to provide the full range of expertise needed to manage loan and loan guarantee programs.
4. Work must continue and be accelerated on the development of complete procedures for awarding loans and loan guarantees, and for monitoring those that have been made.
5. Program personnel must become more cognizant of the need to refrain from making advance commitments to potential loan recipients which cannot, in fact, be legally carried out or are contrary to the best interests of the U.S. Government, and that appropriate checks and balances be established between loan management and program personnel.

If you agree with the above recommendations, I will develop a memorandum to HRA and HSA which will again indicate our concerns, and request that they implement these recommendations. At this time, it does not appear that a study is necessary.

John C. Droke
John C. Droke

EXECUTIVE OFFICER:

Concur

9/11/75

Nonconcur

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health ServiceTO : Acting Administrator
Health Services Administration/PHS

DATE: MAY 19 1975

FROM : Director
Office of Administrative ManagementSUBJECT: Monitoring Hill-Burton, FHA 242 and Health Maintenance Organization
Loans and Loan Guarantees

By memorandum of April 21 (TAB A), the Regional Health Administrator, Region X, recommended that this office take the necessary actions to produce policies and procedures on loan management and listed several loan management activities common to the subject programs. In response, my memorandum of May 9 (TAB B) proposed that a task force be established to identify those areas of loan management which require input from the program offices and those in which a common approach may be established.

The task force should consist of representatives from the Office of Regional Operations, the Office of the Assistant General Counsel/PHS, Health Resources Administration, Health Services Administration and my office. Under the joint leadership of this office and the Office of Regional Operations, it is proposed that the task force identify the specific activities and responsibilities involved and prepare an outline for the development of appropriate policies and procedures. Following approval of the outline, a policy and procedures manual will be developed.

Due to the urgency of this matter, I would appreciate receipt of the name of the individual designated to represent your office on this task force no later than May 23. My office will contact the designated representatives and arrange for the necessary meetings.


John C. Droke

2 Enclosures

OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA FPMR (41 CFR) 101-11.6

UNITED STATES GOVERNMENT

Memorandum

TO : Director, Office of Administrative Management

FROM : Regional Health Administrator, Region X

SUBJECT: Monitoring (Management) of Title VI, FHA 242 and HMO Loans

DATE: APR 21 1975

As the direct lender or guarantor of loans under Title VI of the Public Health Service Act and the HMO Act, the Department is exposed to possible financial loss if loan recipients fail to make loan payments or if they fail to observe covenants designed to protect the financial interests of the lender/guarantor. In addition, DHEW may have some responsibility to HUD for the monitoring of FHA 242 loans, but no such responsibility is defined in DHEW issuances.

Upon completion of a loan closing, activities which I refer to as loan management should begin. These activities, which are more or less common to the subject programs, consist of:

1. Receipt from loan recipients of periodic financial statements and, where applicable, periodic data on insurance maintained by the loan recipient;
2. Procurement of supplemental financial and other data from loan recipients on an as-needed basis;
3. Review of data received to determine whether or not revenues and other sources of funds for loan repayment are sufficient for this purpose;
4. Review of data received to determine whether or not the loan recipient is adhering to the terms and conditions to which it has agreed;
5. Reporting review results to appropriate HEW and HUD offices and, possibly, to holders of Title VI and FHA 242 Loans;
6. Consultation with loan recipients and holders of loans to identify and correct instances of insufficient revenues and of failure to adhere to loan terms and conditions; and
7. Employment of sanctions available to HEW and to HUD to obtain compliance with loan terms and conditions.

Present HRA and HSA issuances do not address the following issues:

- a. What are the procedures to be employed in loan management; e.g., _____

identification of instances in which sanctions are to be employed, notification of HEW and HUD offices?

- b. What are the respective responsibilities of the Regional Offices and Central Offices?

Region X has an aggregate of 15 Title VI, FHA 242 and HMO loans, and I assume that other Regions have comparable numbers of loans. The management of these loans properly and on a consistent basis among the Regional Office requires the development and issuance by Central Offices of policies and procedures for loan management. Since loan management functions are relatively independent of Program objectives, common policies and procedures for Title VI, FHA 242 and HMO loans should be developed and should be administered by a single office within PHS in the Regions.

Since functions 1 through 6 require periodic contact with individual loan recipients, loan holders and HUD Regional Offices, I recommend that these functions be assigned to the Regional Offices. Because of the severity of employing sanctions to obtain compliance with loan terms and conditions, I recommend that this function, for HEW, be assigned to or controlled by Central Offices.

I recommend that you take such actions as are necessary to produce HRA and HSA policies and procedures on loan management.

A related issue is that of staffing. We do not have experience upon which to base an estimate of staff time requirements for these functions. My staff estimates that 10 professional person days, at a GS-7/9 level, per loan per year will be required. For Region X this would require 150 person days for FY 1976. I recommend that these requirements be recognized in budget formulation and justification.



David W. Johnson, M.D.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FHS Regional Health Administrators

MAY 9 1975

Director
Office of Administrative Management

Monitoring Hill-Burton, FHA 242 and Health Maintenance Organization
Loans and Loan Guarantees

By memorandum of April 21 (TAB A), the Regional Health Administrator, Region X expressed concern about the responsibilities of the regional offices with regard to the subject matter and recommended that appropriate action be taken to produce policies and procedures on loan management. In addition to those activities listed in TAB A, there are several areas in connection with loan administration which have an impact on the regional offices and which should be included in the development of policies and procedures. Examples of some of these areas are as follows:

1. Follow-up action with loan recipients and lenders on late payments of principal and interest;
2. conversion of construction financing to permanent financing, including the escrowing of final balances;
3. monitoring of construction drawdowns and advances;
4. recommending appropriate courses of action with regard to defaults, including amounts to be waived, if any, and arranging terms and conditions for repayment of defaulted amounts; and
5. approval or disapproval of requests from loan recipients relative to prepayments on loans, issuances of additional indebtedness, disposal of assets, disposition of insurance proceeds, etc.

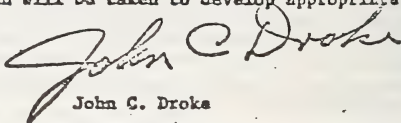
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PHS Regional Health Administrators

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The development of appropriate policies and procedures will involve the Office of the Assistant General Counsel/PHS, Office of Regional Operations, the various program offices within the Health Resources Administration and Health Services Administration, and my office. This matter will be discussed with the appropriate offices and I propose to recommend that a task force be established, consisting of representatives from each of those offices, to identify those areas which may require input from the program offices and those in which a common approach may be established. The task force would then establish a plan for the development of appropriate policies and procedures.

The requirements for staffing the regions to monitor the loan programs will be discussed with the administrations and the Office of Regional Operations. I will keep you apprised of the results of the proposed meetings and the actions which will be taken to develop appropriate policies and procedures.



John C. Droke

Enclosure
cc:

OAM, Pkln. Bldg. Rm. 17-25
OKM, Pkln. Bldg. Rm. 18-07
DFM, Pkln. Bldg. Rm. 18-17
Budget, Pkln. Bldg. Rm. 18-23

LWS:pva/td/5/8/75

Acting Administrator
Health Services Administration/PHS

MAY 2 1975

Director
Office of Administrative Management

Health Maintenance Organization Direct Loan and Loan Guarantee
Commitments to Applicants with Unresolved Issues

On April 9 this office issued policy guidance to the Director, Division of Organization Development/BCMS/MSA relative to the subject matter (TAB A). As a result, the Associate Bureau Director/HMO/BCMS/MSA has requested consideration of informal statements in lieu of written confirmation from the appropriate audit agencies (TAB E).

The procedure to be followed relative to unresolved audit issues has been discussed with the Associate Administrator for Management/MSA and it has been agreed that no direct loan or loan guarantee shall be approved when it is known that Federal audit exceptions exist which could impact upon the security for the loan. This policy is not meant to infer that such loans must be deferred until all audit questions have been totally resolved and the final audit report is issued. However, it does mean that a written statement must be received from the appropriate audit agency, confirming the fact that known audit exceptions have or are being resolved to their satisfaction prior to the closing of the loan. This procedure is necessary to protect the financial interest of the United States and verbal communication shall not be considered as acceptable evidence that such issues are being resolved.



John C. Droke

2 Enclosures

cc:
Mr. Andrew J. Cardinal
Dr. Paul B. Batalden
Dr. Frank H. Seubold
Mr. Robert Schaeffer ✓

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Director
Division of Organization
Development/BCHS/HSA

DATE: APR 9 1975

FROM : Director
Office of Resource Management/OAM

SUBJECT: Health Maintenance Organization Direct Loan and Loan Guarantee Commitments
to Applicants with Unresolved Issues

In response to your memorandum of April 2, this office shares your concern relative to potential financial hazards in committing loans or loan guarantees to the subject applicants when it is known prior to such commitment that unresolved issues exist.

Section 1308 of the Public Health Service Act requires that the terms and conditions of both direct loans and loan guarantees be established and/or modified by the Secretary to the extent necessary to insure that the purposes of this title are carried out, while adequately protecting the financial interest of the United States. The authority and responsibility contained under this section have been redelegated to the Director, Bureau of Community Health Services. Thus, it is clearly the intent that no loan or loan guarantee shall be approved for any applicant when it is known at the time of such approval that any one or more circumstances exist which could impact upon the applicant's ability to repay the loan or otherwise comply with any of the terms and conditions contained in the loan documents, authorizing legislation, or appropriate regulations. Failure to give consideration to all known circumstances in approving each application would not be in conformance with the Act and would not be in the financial interest of the United States.

With specific regard to unresolved audit exceptions, no direct loan or loan guarantee shall be approved until all known Federal audit exceptions have been resolved to the satisfaction of the Secretary or his designee, and evidence to that effect should be in the form of written confirmation from the appropriate audit agency involved. Such audit exceptions are normally associated with the possibility of misapplication of funds resulting from prior Federal assistance or the inadequate accounting for such assistance. The prototype loan closing documents established for subject program contain a requirement that the applicant shall be responsible for keeping full and proper books of record and accounts in a manner conforming to normal accepted accounting principles. The Secretary or his designee is responsible for determining the existence of adequate and proper accounting records prior to endorsing such loan closing documents.

Director
Division of Organization
Development/BCHS/HSA

2

Commitments to direct loan applicants are conditioned upon the furnishing of credit instruments which are acceptable to the Secretary at/or prior to the endorsement of the loan. Thus, it would not appear to be necessary to modify the direct loan commitment to specifically include conditions pertaining to audit exceptions. However, guaranteed loans may present somewhat of a different problem in view of the incontestable nature of such commitments. Therefore, it may be considered prudent to modify the loan guarantee agreement on a case-by-case basis, to specifically include known audit exceptions and thereby condition the endorsement of the agreement upon the satisfactory resolution of such audit exceptions.

In spite of the most careful and detailed analysis and financial feasibility review prior to the approval of a loan or loan guarantee, it is possible that situations may subsequently arise relating to both prior Federal assistance and the disbursement and use of the loan proceeds. Such situations must, of necessity, be promptly dealt with as each becomes known to the program office. However, under no circumstances should a loan or loan guarantee be endorsed when it is known at the time of such endorsement that unresolved problems of the nature indicated above exist.



William E. Muldoon

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
Bureau of Community Health Services

TO : Director
Office of Administrative Management
Attention: Loan Policy Officer
Office of Financial Management, H

DATE: April 2, 1975

FROM : Director, DOD

SUBJECT: HMO Loan/Loan Guarantee Commitments to Applicants with Unresolved
Federal Audit Exceptions

As you will recall, there were several unresolved audit exceptions, reflected in reports of the DHEW Audit Agency relative to Sound Health, Inc., Tacoma, Washington. This was one reason that this Division's recommendation was not to make a loan to this organization, although the overall recommendation reflected major questions of financial viability.

Several loan applications are currently being processed. Several of them have DHEW Audit Agency and General Accounting Office Audit reports specifying exceptions of varying degrees of seriousness, and as yet unresolved.

It seems to me the Department policy regarding full faith and credit guaranteed loan/loan guarantees under P.L. 93-222 should be unequivocal as to how such unresolved audit questions, whether by an agency of this Department or another Federal audit agency, are dealt with at the time loan or loan guarantee commitment is proposed. Exceptions reflecting improper handling of previous Federal assistance, whether grants, loans or contracts, should either be formally resolved, or the agency concerned should indicate to this Bureau, in writing, that the situation reflected in the exception is in an acceptable state of progress toward resolution by the applicant prior to any loan or loan guarantee being endorsed. Either this should be a formal provision in our commitment documents, or an external requirement preceding endorsement.

In summary, I am recommending that a policy stance be explicitly established regarding HMO loan and loan guarantees proposed for any applicant who has been audited by a Federal agency, and for whom any exceptions in the handling of previously given Federal assistance have been raised. These exceptions should be resolved to the satisfaction of the audit agency, and the adequacy of the solution reflected in writing to us, prior to our recommending any additional Federal loan or guarantee assistance provided under P.L. 93-222.

Director, Office of Administrative Management

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The most common difficulties in evidence so far among HMO applicants encompass questions of eligible expenditures, adequacy of accounting systems, proficiency of general management, conflicts of interest, conformance with formal applicant assurances, legal conformance with State/local requirements (if condition of Federal assistance), etc.

I think we should have the option at program level to commit a loan, with the resolution of audit exceptions as a standing condition preceding endorsement, but that we should not endorse an HMO loan or loan guarantee without specific written confirmation from the audit agency involved that outstanding exceptions have been resolved, or that an acceptable state of progress toward their resolution has been attained by the applicant.

An early response would be appreciated.



Robert L. Schaeffer

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health ServiceTO : Director
Division of Organization Development/BCHS/HSA/PHS

DATE: MAR 10 1975

FROM : Director
Office of Resource Management/OAM

SUBJECT: Depreciation and Amortization under HMO Loan Program

In response to your memorandum of March 3, this office is in agreement with the concept that established procedures outlined in the Medicare Provider Reimbursement Manual be utilized where possible to provide a basis for our own actions on similar issues under the subject program.

Guidance is provided on the specific issues outlined in the memorandum of February 28 from Mr. Perkins and enclosed with your memorandum, as follows:

1. Depreciation expense may be considered an allowable operating cost under the subject program and the methods for determining the cost of physical assets and distribution of depreciation expense outlined in the Medicare Provider Reimbursement Manual may be utilized in their entirety, with the exception of the "Optional Allowance for Depreciation Based on a Percentage of Operating Cost" outlined in Section 124, Chapter 1, of such manual. Basically, the manual provides that: (1) depreciable assets be capitalized on the basis of historical cost; (2) guidelines published by the American Hospital Association or the Internal Revenue Service may be utilized to determine useful life of depreciable assets or other bases may be utilized but must be supported by adequate documentation, when such bases differ materially from such guidelines; (3) three basic methods of prorating depreciation expense may be used which include straight-line, declining balance, and sum-of-the-years' digits, but once a method is established for a particular item or group of items, such basis may not be changed without the prior written approval of the Secretary, and; (4) minor equipment may be either depreciated or written off as operating expense at the time of purchase, provided that the basis selected is consistently applied and may not be changed thereafter, without the prior written approval of the Secretary.

While it is recognized that either the declining balance or sum-of-the-years' digits method of depreciation may result in an applicant's writing off a major portion of the assets' value during the 36-month period of our assistance, both methods are considered

Director
Division of Organization Development, DCMS/MSA/PMS

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acceptable under the Internal Revenue Service Code and the Medicare Program and failure to permit such practice on our part may necessitate revisions, with resultant complications, in the applicants' established accounting procedures. Thus, this office has no objection to permitting the adoption of such methods as an option under the subject program.

2. Amortization of organization costs may be considered an allowable operating cost under the subject program. Again, this office favors the approach outlined in the Medicare Provider Reimbursement Manual under Section 2134, Chapter 21. In the formation of most corporations, the types of costs which may be capitalized as "organization costs" are much broader than those outlined in this manual. However, it should be noted that this manual contemplates the segregation of such costs between organization costs and start-up or development costs.

Under the Medicare Provider Reimbursement Manual, organization costs include only those costs associated with establishing the corporation or organization, and other costs associated with the promotion and organization of the concern or the raising of capital are excluded. Organization costs are amortized on the basis of 60 months, on a straight-line basis, beginning on the date of incorporation or organization. This basis is mandatory and no deviations are permitted. Such practice is recommended and, if adopted, should be consistently applied under the subject program.

3. Amortization of start-up costs may be considered an allowable operating cost under the subject program. Section 2132, Chapter 21, of the Medicare Provider Reimbursement Manual may be utilized in determining the types of costs which may be capitalized and the amortization period. It is noted that start-up costs include all costs associated with the operation and maintenance of an organization and not properly classifiable as organization expenses or construction costs, from the time the organization is formed until the first patient is treated. The amortization period is the same as for organization costs, namely 60 months on a straight-line basis.

In connection with the subject program, it is recommended that start-up costs be capitalized up to the point in which the HMO organization first provides service to a subscriber, whether or not such organization was a qualified HMO at that time. This should also be the date which begins the 60-month period of amortization.

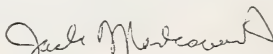
Assuming that an organization has already capitalized their organization and start-up costs and are carrying such costs as a single item on the balance sheet, this office would have no objection to amortization of such cost as a single item, consistent with the above criteria. In other words, the date on which the organization first

Director
Division of Organization Development, BCHS/HSA/PHS

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provides service to a subscriber would begin the 60-month period of amortization and no costs could be capitalized following such date.

4. Depreciation of physical assets may be considered an allowable cost under the subject program regardless of the source of funds or origin of such depreciable assets. However, where an applicant for a loan or loan guarantee has received reimbursement from Federal funds for the purpose of assisting in meeting costs of organization and/or development, the amount of such assistance must be deducted from the total cost of organization or start-up expenses prior to determining the allowable amortization of such items under the subject program.


William E. Muldoon

Director
Office of Administrative Management
Attention: Loan Policy Officer

March 3, 1975

Director, DOD

Depreciation and Amortization under HMO Loan Program

The enclosed memorandum from Mr. Perkins indicates areas in which a policy decision is required.

Certain selected Procedures in the Medicare Provider Reimbursement Manual are appropriate for use within the HMO program; others require some modification. It will serve everyone's interests if existing procedures under the Medicare program can be used without change in all possible instances, and that those closely similar to HMO requirements be modified as necessary. This will provide a basis for Department action using already existing precedent with which the health care industry is thoroughly conversant.

Mr. Perkins is available to work with you, as required, in making these determinations.

Robert L. Schaeffer

Robert L. Schaeffer

Enclosure

cc: Dr. Frank H. Seubold
William J. Stanley

BCHS:DOD:RLSchaeffer:jsc 3/3/75
cc: DOD:O.F.
DOD:R.F.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

TO : Director/DOD/BCHS/HSA ✓

DATE: JAN 20 1975

FROM : Loan Policy Officer/H

SUBJECT: Revision of Loan Guarantee Agreement for HMO Loan Guarantee Program

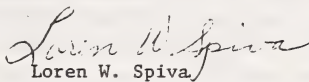
The subject agreement has been revised in accordance with our discussion in your office January 17. The original agreement, drafted February 21, 1974, contained certain provisions which were established prior to the publication of the Regulations.

The changes which have been made on the revised agreement are as follows:

1. The original draft provided for planning and initial development projects for expansion only. Since this provision is at variance with the Regulations, it is believed desirable that it be revised to provide for planning and/or initial development projects, both for new projects and expansion. Although such projects may not be able to meet feasibility criteria in accordance with Section 1308 of the Act, it is best to handle this situation as policy or as a part of the financial feasibility review process. Otherwise, we may be cited as prejudging the application.
2. The original draft specified quarterly disbursement of funds. The revised agreement provides for monthly disbursement and is believed to be more flexible.
3. The original draft indicated that a paragraph dealing with interest rates was to be written for such individual agreement. The revised agreement sets forth the structure of the maximum interest rate by the Secretary at the time of the loan endorsement.
4. The original draft specified monthly repayment of the loan. This is at variance with the Regulations and has been revised to provide for repayment on any basis up to annual level debt service.

Director/DOD/BCHS/HSA

I believe the enclosed revised agreement is more flexible than the original draft and is more nearly in conformance with the Act and the Regulations. Copies are being provided to all participants of the January 17 meeting and, following review by such participants, a second meeting is to be held to discuss the revision and decide whether to provide prototype loan closing documents or guidelines.


Loren W. Spiva

cc:

David Benor

Donald Perkins

William Stanley

Dr. COOPER. Now, before you have to terminate, I just want to comment on the bills that are being considered.

As you know, basically, we are in full accord with the intent of that which is being considered. There are some problems that we see, and we don't agree with every specified proposal.

With respect to S. 1926, the Department concurs in: the deletion of the requirement for open enrollment, transfer of the medical treatment and referral services for the abuse of or addiction to drugs and alcohol, home health services, and children's preventive dental benefits from the basic benefits to supplemental service categories, and the redefinition of preventive health services; the part about the participation of other health professionals; the removal of the requirement that a medical group which contracts with an HMO must have service to the HMO as its principle professional effort; the expansion of the authority to use loan guarantees; the provision to permit more effective use of the loan authorities; the provision for mandatory offering of the HMO option only if at least 25 employees reside in the service area of the HMO.

I would strongly emphasize our opposition to the community rating provision even with the 5-year deferral. Of course, we object to the authorization levels recommended in the bill and recommend the President's current level of \$18 million and a 1-year extension, as in my full statement.

Senator KENNEDY. Do you expect the person that is chronically ill to pay a higher premium than somebody else?

Dr. COOPER. Well, I would like to not have that burden, but in the practical situation as it really exists, experience rating is used as, of course, you know.

I am interested in accomplishing two things. One, in the long run, I would like to insure access to quality care for every citizen at reasonable cost.

Senator KENNEDY. When are we going to get your bill on that?

Dr. COOPER. Well, the decision hasn't been made on the timing of that yet, Mr. Chairman. But I would hope that we could address that because a portion of HMO deals with that, as you have said yourself before. And, obviously, ideally I would like to have no price barrier, but I am most urgently concerned at the moment that the idea of the HMO get a fair trial and become a competitive instrument and a source to the pluralistic system.

Although experience rating is a fact that we have to live with, I am trying to find a way to expedite the survival and development of these instruments, particularly in the rural and underserved setting.

Senator KENNEDY. I suppose the question is. Do we have to live with it? I mean that because the system is out there, do we have to conform the Federal programs to it?

Don't most of the HMO's now community rate?

Dr. COOPER. Well, Frank?

Dr. SEUBOLD. Actually, in this particular context, they operate on the community rating principle. But in most instances, I think that you will find that there are certain exceptions to this with respect to particular groups.

Furthermore, there is the factor that today they can adjust their benefit packages according to the resources of the particular groups

that are involved. So that, even if they maintain the cost, let's say, per benefit, on a community basis, by adjusting the benefits that are offered, they can still offer a reasonable comprehensive package at a relatively low cost for those groups that can afford only such costs.

Senator KENNEDY. There was a comparison of cost of HMO's under the HMO Act of 1973. It was done—prepared for your office of planning evaluation—HSA—for September of this year. Are you familiar with that? It was a preliminary.

Dr. COOPER. We have it over—

Senator KENNEDY. Fleckinger was the fellow who prepared it. Are you familiar with that?

Dr. COOPER. We have it. It is right here.

Senator KENNEDY. Now, I am quoting from the preliminary draft here. This is what they say. This is on page 32. I'll mention this to you and then ask you sort of a general comment.

Observations: Legislation reducing the range of mandated and supplemental benefits does not appear to be warranted if the sample of 17 PHP's is broadly representative of the range of benefits provided.

Capitation rate, as shown in table 2.1, the basic services such as dental care for children, alcohol and drug abuse, and family planning does not seem excessive from a cost competitive viewpoint.

And then it continues:

Open enrollment in community rating have not been specifically addressed, although dual choice is the feature of all the PHP's examined during this study. As Public Law 93-222 allows waiver of open enrollment requirements if the plan's economic viability is jeopardized, the open argument should be noted.

Now that is the preliminary draft. Here is the final draft and under "Implications."

The largely unlimited coverage of a wide range of benefits—basic benefits, coupled with open enrollment in community rating, required by the HMO Act of 1973, appears destined to render HMO's outside the effective competitive range unless there is legislative relief in the areas of coverage limitation, enrollment, and pricing policies.

Now that is the exact same data. One was the preliminary and one was the final draft 2 months later by the same person—reaching an entirely different conclusion, with the same data.

Can you help me a little bit?

Dr. COOPER. I can't help you on that because I have not talked to the author of the—

Senator KENNEDY. No, I wouldn't expect you to—

Dr. COOPER. I meant perhaps some of the staff can.

Dr. SEUBOLD. Yes, if I may address that, Mr. Chairman. There was additional information generated between the time the preliminary draft was obtained and the final draft, particularly in terms of assessing the competitive nature of these HMO's relative to the benefits and prices from indemnity coverage in the wide range of areas beyond those that were first addressed in the preliminary report.

I believe, if I may interpret these authors, that as they look at the overall competitive situation, they do not change their position with respect to the exact price for certain of these required benefits.

However, in looking at the overall picture in what people were buying and what they were paying for, the combination then of the restricted benefits with the requirement for open enrollment—and

they have data on that which indicates that those people who come in on individual, open enrollment utilize at least 25 percent more services and cost about 25 percent more than those who came in under group involvement—plus the additional restriction which is not applied to the competitive health providers puts the HMO in a total picture of being not competitive.

This now, I think, speaks to the issue of providing real flexibility for these organizations in how they tailor the specialized parts of their benefits, how they are able to overcome the problem of open enrollment and how they are able to compete on a head-to-head basis through the use of experience rating.

All of these factors together can give the HMO a real opportunity to penetrate the health care market. Whereas, without this kind of relief, their situation is far more difficult.

Senator KENNEDY. Well, can you provide for us what that additional information was—the new information that was developed after the preliminary draft that led to the conclusions on the second report?

Dr. SEUBOLD. Yes. We will provide that for the record.

Senator KENNEDY. And whatever material you have to substantiate your position on the issue of open enrollment.

Dr. SEUBOLD. Yes, sir.

[The material referred to follows:]

General Research Corporation Study "Cost Competitiveness of Health Maintenance Organizations"

The GRC preliminary report contained two major weaknesses. When these were pointed out and additional data supplied the report was corrected accordingly. The weaknesses and the new data are as follows:

1. Competitiveness of HMOs who have to market the mandated basic health services.

GRC compiled data from 68 major employers in 9 cities:

Boston, Providence, Trenton, Miami, Minn./St. Paul, Lexington, New Orleans, Houston, Milwaukee. On the basis of that data, GRC concluded in the preliminary report that, "Legislation reducing the range of mandated and supplemental benefits does not appear warranted...."

HMO staff used the very same data and compared it with new information obtained from applications for qualification and from grantees' marketing studies. The enclosed Chart 1 includes the GRC data and the new information.

The chart indicates that in virtually every one of the cities listed existing non-qualified HMOs premiums already were higher than non-HMO coverage and that qualified HMOs would have to charge even more than non-qualified HMOs. The resulting premium differential is overwhelmingly unfavorable to HMO competitiveness.

This new information was developed in October, 1975. By the time of the hearings in late November, 1975, more data of a similar nature had been gathered and these data provided the basis for the reference in Dr. Cooper's prepared statement that, "data from over 605 employers in 17 cities...shows that 77 percent of the 605 firms had health benefits which cost \$20-57. Most of the basic benefit rates of organization applying for qualification estimate basic benefits at \$70 or more for a family." (See Chart 2).

The new information largely accounts for why GRC revised key sections of the preliminary report.

2. Failure to account for limitations and exclusions as a means of reducing the premium.

In the preliminary report GRC did not account for the effects of placing limits on certain benefits and excluding others when it surveyed the 17 prepaid health plans.

- 3 -

HEW staff used the benefit brochure from one of the 17, the Hunter Foundation, in Lexington, Kentucky to illustrate what a more detailed analysis than the one performed by GRC would reveal.

This analysis does not include every variation of the Hunter Foundation from P.L. 93-222. Without having available all the contracts between the HMO and other parties a complete analysis is not possible.

MAJOR DIFFERENCES BETWEEN REQUIREMENTS OF P.L.93-222 AND CURRENT
STATUS OF AN UNQUALIFIED ORGANIZATION

HUNTER FOUNDATION FOR HEALTH CARE, INC. LEXINGTON, KY.

\$50/family/mo.

I. BENEFITS

- Dentistry excluded from basic services
- Organ transplants and chronic renal dialysis excluded
- Hospital Coverage for a potential member doesn't begin
until discharge from hospital
- Surgery for corrective deafness excluded
- Pre-existing conditions excluded until 12 months of continuous
due coverage has elapsed
- Major disaster or epidemic liability excluded
- In-patient hospital care for contagious diseases, mental
illness, drug dependence or abuse, or alcoholic disorders
limited to 30 days maximum/year.
- Psychiatric care, alcoholism, drug abuse limited to a total
of \$500/yr/per member
- Payment for out of area care for accidental or emergency
illness subject to dollar limitations

II. ORGANIZATIONAL REQUIREMENT

- Community Rating is not practiced

III. CONTRACTUAL ARRANGEMENTS

- Hospitals are responsible to members for all Hospital
Services instead of the HMO

CHART 1 REGION		RATES FOR INSURED HEALTH BENEFITS*	EXISTING RATES NON-QUALIFIED PREPAID PLANS**	COST OF BASIC HEALTH SERVICES FAMILY RATE***
<u>North East</u>				
Boston		\$40-45 (7 employers) \$65-74 (3 employers)	HCHP - \$72.88 (Boston)	New Haven - \$68.15
Providence		\$39-57 (4 employers) \$60-67 (2 employers)	RIGHA - \$63-85 (Providence)	Pittsburgh - \$69.49
Trenton		\$33-45 (4 employers) \$59 (1 employer)	Mercer- \$46.10 (Trenton)	E. Orange, N.J. \$64.83
<u>South East</u>				
Miami		\$29-44 (15 employers) \$65-82 (3 employers)	American Health Plan (Miami) - \$44.65 Clinica Association Cubana (Miami) - \$64	Miami - \$78.42
<u>Central</u>				
Milwaukee		\$28-58 (8 employers) \$63-69 (2 employers)	COMPARE (Milwaukee) - \$81.70	Detroit - \$90.40
Minn./St. Paul		\$32-59 (10 employers)	Metro Health Plan (Detroit)	Chicago - \$77.15
Kansas City		\$37-60 (11 employers) \$61-80 (2 employers)	\$50-80	Madison, Wisc. - \$72.00
St. Cloud, Minn.		\$35-58 (12 employers) \$65-76 (2 employers)	Nicolette-Eitel (Minn./St. Paul)	Evansston, Ill. - \$66.57
Rock Springs, Wv.		\$35-39 (5 employers)	\$38.50	Kansas City - \$70.00
			Share Health Plan (Minn./St. Paul)	St. Cloud, Minn. - \$65.50
			\$68	Rock Springs, Wv. - \$56.85
			Anchor (Chicago) - \$57.16	
<u>South Central</u>				
Lexington, Ky.		\$31-45 (4 employers)	Hunter Foundation -(Lexington, Ky.) \$50	Louisville, Ky. - \$71.18
Louisville, Ky.		\$33-55 (12 employers) \$59-75 (5 employers)		Greenville, S.C. - \$57.00
Baton Rouge, La.		\$20-65 (92 employers) \$66-75 (10 employers)		Baton Rouge, La. - \$69.00
New Orleans, La.		\$43-49 (4 employers)		
<u>South West</u>				
Houston		\$21-54 (10 employers)	Group Health Care Plans (Houston) \$66	Houston, Tex. - \$72.00
		*GRC Survey	**Twin City Health Care Project	***Application for Qualification and grantee estimates

CHART 2

CITY	EMPLOYER SURVEY Rates for Insured Health Benefits						EXISTING RATES NON-QUALIFIED PLANS	BASIC BENEFITS RATE (FAMILY)
	\$20-29	\$30-50	\$51-57	\$58-68	\$69+			
Louisville, Ky.		10	2	4	1			\$71.18
Lexington, Ky.		4					\$50.00	
Miami, Fla.	3	2		2	2		44.65-84.00	78.42
Kansas City, Mo.		22	4	5	5			70.00
Eaton Rouge, La.	11	36	23	15	6			69.00
Rock Springs, Wyo.		5						56.85
		(all \$35-40)						
Trenton, N.J.		4		1			46.10	64.83 (E. Orange)
St. Cloud, Minn.	1	11	2	2	1			65.50
Houston, Tex.	2	44	27	19	4		66.00	72.00
Milwaukee, Wisc.	2	3	2	2	1		81.70	
Minn./St. Paul		6	2	2			63.85	0
Providence, R.I.		3	1	2				63.50
Boston, Mass.		6		1	3		72.88	
New Orleans, La.		4						
Pittsburgh, Penn.		2	2	1				69.49
Philadelphia, Penn.		11	5	4	2			60.08
Albany, N.Y.	15	141	49	39	14			67.00
TOTALS	34	314	119	99	39			16.

Of the 605 employers, 77% offered their employees health benefits which cost \$20-57 per month. The average Qualified HMO will have to charge \$70-75 per month.

Current data on open enrollment has been obtained from three sources

1. The Marshfield Clinic
2. Northcare - a qualified HMO
3. New Jersey Blue Cross

These data are enclosed as Tabs A-C. The Marshfield average cost per capita of non-group members has been 37 and 1/2 percent higher than that of group members. Northcare experience was 37 percent higher. The New Jersey Blue Cross experience was 35-40 percent higher immediately and rose to about 60 percent higher after pre-existing conditions were dovered.

OPEN ENROLLMENT

1. Marshfield, Wisconsin Study
2. NorthCare Experience
3. New Jersey Blue Cross Experience

MARSHFIELD STUDY OF GROUP AND NON-GROUP ENROLLEES UTILIZATION AND HEALTH CARE COSTS

NONGROUP ENROLLEES	23.0% OF MEMBERS
NONGROUP ENROLLEES	29.9% OF HEALTH COSTS RESOURCES
NONGROUP ENROLLEES	USE 25% MORE HEALTH CARE
NONGROUP ENROLLEES	NEARLY 300 DAYS/1,00 MORE
MEAN COST	\$4.22 PM/PM HIGHER

OPEN ENROLLMENT EXPERIENCE - ONE QUALIFIED INDIVIDUAL

	BENEFIT MONTHS	OFFICE VISITS PER BENEFIT YEAR	HOSPITAL DAYS PER BENEFIT YEAR	TOTAL COST PER BENEFIT MONTH
ALL GROUPS	11,909	5,392	.333	\$26.59
OPEN ENROLLEES	4,299	6,395	.435	\$32.41
CITY EMPLOYEES	3,178	4,078	.461	\$24.11
UNIVERSITY ENROLLEES	1,835	5,513	.163	\$23.45



**North Communities
Health Plan, Incorporated**

1718 Sherman Avenue
Evanston, Illinois 60201
Phone 312. 864. 1900

October 7, 1975

Mr. George Strumpf
Department of Health, Education & Welfare
5600 Fishers Lane - Room 13A23
Parklawn Building
Rockville, Maryland 20852

Dear Mr. Strumpf:

In March, NorthCare did have an open enrollment, which was designed to meet HEW requirements. Our decision to proceed so early with such a high-risk endeavor was motivated by a special circumstance. The operating plan, NorthCare, was preceded by a 3-year community effort under the auspice of an organization referred to as the Evanston Medical Consumers. People joined and supported that venture believing that there would be accessibility if and when a plan eventually emerged. We did not want to alienate this important constituency.

As you can see from the enclosures, we got excellent media visibility. The marketing staff insisted that this was a far better approach than paid advertising. They were right! We wanted visibility for another reason as well. Our actuary, J. Wiley Clements, warned us that if we dared to undertake an open enrollment, there must be a wide awareness of the Plan if we wanted to assure incorporating as many good risks as possible in order to offset the inevitability of adverse selection. His point of view was that those people with severe health problems will emerge, no matter how low-profile the effort.

We do, in fact, have quite a bit of experience on the open enrollment population as compared with other employer groups. My impression is that it was not nearly as negative an experience as I would have expected. Also, it proved an outstanding community relations gesture. There are, however, some special circumstances that I should share with you. While NorthCare likes to think of itself as having gained (in March) broad attention and interest, we in fact, were a developing plan, and to many sick people whose principal concern was their health, not very believable. In spite of the economic advantages, there appeared to be an unquestioned hesitation to change from their existing pattern of care. Also, we benefitted from the fact that open enrollment ended two months prior to beginning operations. The complications of having to make interim arrangements also may have been a barrier for people with existing health problems.

October 7, 1975
Mr. George Strumpf

page 2

Notwithstanding the above comments, I have severe reservations about another open enrollment. As an established plan, those factors that I discussed above would work against us. My greatest apprehension would come from within the insurance industry itself. During the last few days of open enrollment, I began to get some very scary phone calls from local insurance agents who wanted to be heroes to their clientele. NorthCare was an easy answer, in that if he could solve the problems of his uninurable clients, the agent would then place himself in a highly desirable position to maintain the other, more lucrative lines. NorthCare's exposure in this sort of situation would be extraordinary.

So, that's the story of our open enrollment experience. The debate within our organization continues. In fact, I am enclosing a position paper that I wrote on the use of medical statements as one reasonably compassionate design for a modified, continuing open enrollment.

If I can be of any other assistance, please feel free to call me.

Sincerely yours,

NORTH COMMUNITIES HEALTH PLAN, INC.



Ernest W. Libman
Executive Director

EWL/eg
enclosures

cc: H. Rhetta, M.D.



**North Communities
Health Plan, Incorporated**

1718 Sherman Avenue
Evanston, Illinois 60201
Phone 312. 864.1900

COMPARISON OF VARIOUS NORTHCARE GROUPS UTILIZATION OF SERVICES: 5/1/75-8/31/75

	CITY OF EVANSTON #75001		FOUNDATION* #75004		STATE NATL BANK #75006		ALL
	Actual	PerCent	Actual	PerCent	Actual	PerCent	
TOTAL MEMBER MONTHS	3206 796	25.5	4861	38.7	336	2.7	12,547
In Office Encounters	1091	18.6	2675	45.6	156	2.7	5,842
Out of Office Encounters	25	24.1	45	43.3	2	1.9	104
Referral Care	37	17.7	126	61.2	3	1.4	209
Referral Care Cost	\$877.15	10.4	\$6412.60	76.0	\$77.50	.1	330
Hospital In Patient	17	43.6	16	41.2	1	2.6	
Hospital In Patient Days	122	37.0	169	51.2	4	1.2	
Hospital In Patient Cost	\$24576.01	41.5	\$25929.41	43.8	\$914.75	1.5	
Hospital Out Patient	42	27.3	83	55.3	3	2.0	150
Hospital Out Patient Cost	\$2051.25	24.8	\$5035.35	61.1	\$63.35	.1	

* Foundation Group is Open Enrollment Group

10/8/75
RSG

NORTHCARE EXPERIENCE, 5/1/75 - 8/30/75

	Benefit Months	Office Visits per Benefit Year	Hospital Days per Benefit Year	Cost per Outpatient Visit	Referral Physician Cost per Service	Outpatient Visit Cost per Benefit Month	TOTAL COST per Benefit Month
All Groups	11,909	5,392	.333	\$42.66	\$42.81	\$19.17	\$26.54
Open Enrollment	4,299	6,395	.435	43.34	50.42	23.10	32.44
City Employees	3,178	4,078	.461	42.21	36.67	14.35	24.11
North- western University	1,835	5,513	.163	43.10	29.28	19.80	23.45

NEW JERSEY BLUE CROSS EXPERIENCE

July 1973 - Conducted statewide open enrollment by order of State Insurance Department.

September 1, 1973 - Effective date of coverage - Blue Cross required to accept all applicants, regardless of health status, but the contract did exclude for 1 year coverage of conditions existing on effective date.

9/1/74 - 8/31/74 Experience: Premium \$1.8 million

Claims 2.3 million (+28%)

Pre-existing waiver expired 8/31/74. For the same group of enrollees, subsequent experience deteriorated further:

9/1/74 - 12/31/74 Experience: Premium \$545,000

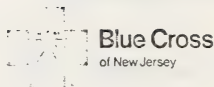
Claims 846,000 (+55%)

Source: Press release dated 5/30/75 from N.J. Blue Cross Public Relations
V.P., W. Jefferson Lyons

Press Release

W. Jefferson Lyon
Vice President
Public Relations
1/456-2522

Washington Street
Newark, New Jersey



For Release Upon receipt

Experiments in waiving health requirements for non-group membership are imposing a heavy drain on the reserve funds of New Jersey Blue Cross subscribers, according to a new report on "open enrollment" experience.

In July 1973, at the request of the State Department of Insurance, the Plan accepted applicants for non-group membership regardless of their health. During the first 12 months of membership (September 1973-August 1974), the Plan incurred a loss of over half a million dollars in providing benefits for these members, even though pre-existing health conditions were not covered during that first year.

An analysis of the cost of providing benefits for this membership category shows that during the first year Blue Cross received \$1.8 million in premium income from these members and incurred claims amounting to \$2.3 million.

✓ A Plan spokesman said the loss would have been even greater if there had not been the 12-month bar on pre-existing conditions. During the first 12 months of any non-group membership, whether the result of "open enrollment" or the regular on-going non-group program which is subject to health underwriting, Blue Cross does not provide benefits for any health condition that exists at the time of or prior to enrollment.

The pre-existing condition restriction ended September 1 for the group enrolled in July of 1973 and the cost of providing benefits for these members increased thereafter. During the last four months of 1974, Blue Cross received \$545,000 in premium income from these members and incurred claims amounting to \$846,000.

-more-

-2-

Experience during this four-month period, (September 1974-December 1974), together with increasing hospital costs, indicates that the loss for these members during the second year will exceed a million dollars.

The Plan also complied with an Insurance Department request to conduct another "open enrollment" last November, with membership effective January 1, 1975. The report does not involve the 15,000 subscribers who joined at that time. Meaningful statistics will not be available until late this year or early in 1976.

"We have no reason to expect that their experience will be any better than for last year's group," the spokesman said.

-30-

May 30, 1975

Senator KENNEDY. In your earlier comments on the administration of the program, Dr. Cooper, what is your time frame on it?

Dr. COOPER. The staffing commitments for expansion both of the regional staff and the headquarter's staff have already been made. The recruiting is in process as the GAO report said. It is true that we have received the applicants and we have a required process to go through. And we will try to do that in a way that insures the appropriate procedure there. That is in process.

The detailing of positions as I asked for earlier this week is also in process. So that there is no reason why the Administrator, HSA, cannot proceed to deal with the backlog as rapidly as possible, right now.

Senator KENNEDY. Can you tell us a little about preemption? Why has there been such reluctance to moving in that direction on State laws?

Dr. COOPER. Well, I think on the question of State laws, we had taken the position that we would try to work constructively with the States. And, in fact, our own experience is that we have made grants to the States where it has been appropriate and we are not perceiving, at the present time, that this is a major impediment to progress.

Perhaps Dr. Seubold would want to comment in some detail. I don't think there is any reluctance on our part to deal with this issue.

Dr. SEUBOLD. Actually, this is quite true. We have not allowed the fact that there are certain State laws and regulations which could prove inhibitory to HMO operations to interfere with the awards of grants in particular States. I would like to give you just two examples of this.

In the State of Texas, for example, there was considerable confusion whether or not HMO's of any style could operate there, but we did fund projects in the State and at the same time we were invited to work with the State legislators and commissioner of insurance also, with respect to developing appropriate HMO enabling acts. Such an act was, in fact, passed and is now in effect, and these organizations which we supported will be able to move forward.

A slightly different circumstance occurred in the State of Louisiana which had rather hazy legal structure with respect to the possible operation of HMO's there. Also, we did make grants and we have met with the attorney general, the commissioner of insurance and the other State officials. As an outcome of these discussions, the attorney general has put out an opinion that organizations that meet the qualifications of the HMO Act will, in fact, be able to operate in that State.

I think we prefer to work on a cooperative basis with the States recognizing their prerogatives. However, in an instance in which there was no headway to be made cooperatively, and this program and the Office of General Counsel would concur on the fact that there would be no reasonable alternatives, we would be prepared to support these projects with grants and funds in the event that an action was leveled against them by the State.

Senator KENNEDY. Well, do you need stronger legislation on that issue? Would that be helpful?

Dr. SEUBOLD. Well, from an operational standpoint, sir, it appears to be working well.

Senator KENNEDY. I am not sure that you can read the GAO report and reach that same conclusion.

Dr. COOPER. I might say we have no reason to reject any help. We have no help to recommend.

Senator KENNEDY. All right. Let me ask, on another subject, if I could just briefly, Doctor. Can you talk about any phase 4 controls for all health services? I think we all are troubled by the enormous increase in the costs of health.

Dr. COOPER. Are we considering that?

Senator KENNEDY. Yes.

Dr. COOPER. We are considering that question. The Department is considering a whole range of options for recommendations to deal with this problem of escalation of cost controls.

It is clearly the preeminent problem at this time that is driving a lot of considerations of health policy. It is in the list of things that are being considered by the Secretary for recommendation.

Senator KENNEDY. Could I submit some questions to you?

Dr. COOPER. Surely. We would be delighted.

Senator KENNEDY. I want to thank you all. It has been a very useful hearing. Your comments in the early part have been very helpful to us and let me just say I think very encouraging.

Dr. COOPER. We are committed to the program.

Senator KENNEDY. And I think if it is going to be a question about getting additional personnel to try and make these programs work, I am going to be of whatever help and assistance that I can.

I want to thank you all.

At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

[The prepared statement of Dr. Cooper and material referred to follows:]



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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

THEODORE COOPER, M.D.

ASSISTANT SECRETARY FOR HEALTH

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

FRIDAY, NOVEMBER 21, 1975

Mr. Chairman and Members of the Subcommittee:

It is a pleasure to appear today before your Subcommittee to discuss the program we are implementing under P.L. 93-222, the Health Maintenance Organization Act of 1973, and two bills--S. 1926 and H.R. 9019--to make certain amendments to the Act and extend its authorizations for two additional years.

P.L. 93-222 authorized the Federal government to provide financial and other assistance for health maintenance organizations in order to demonstrate the HMO concept in various geographic areas. This initiative involves a partnership with the private health care sector to promote organization and efficiency in the delivery of comprehensive, high quality services on a prepaid basis.

P.L. 93-222 authorized two major forms of Federal assistance. The first was a five-year program of Federal financial assistance in the form of

grants, contracts, loans, and loan guarantees. The second required employers to offer their employees the option of joining a qualified HMO (one which meets the law's requirements) as an alternative to the employers offer of other health care plans.

It is hardly surprising that such innovative legislation as this would, on implementation, be found to contain unanticipated problems which will require correction if the full benefit of the Act to the public is to be realized. There have been administrative problems, certainly--and measures have been taken to correct them. But some problems are inherent in the Act itself. We appreciate the prompt attention this Subcommittee is giving this issue so that effective steps can be taken to assure its greater success.

The Department too has recognized the barriers to the effective implementation of the HMO Act, and our testimony today is in substantial agreement with many portions of both S. 1926 and the similar House bill, H.R. 9019. Our basic consensus on most of the issues hopefully will speed the process of legislative action.

Background

The HMO program is designed to give HMOs a fair market test to determine if their method of operation and costs will be preferred to other financing arrangements by a substantial segment of the population. The results to date are encouraging, though not definitive. HMOs have generally achieved significant cost containment, largely by appropriate reduction in expensive inpatient care. In most instances, the cost of inpatient care in HMOs has been and continues to be about one-half the national average. Available data show that new HMOs are measuring up to their predecessors.

The utilization data shown on Chart I shows that prototype "HMOs" surveyed in 1968 demonstrated 53 percent less utilization of inpatient services than traditional health care and that a half dozen newer plans sampled this year showed similar reductions. Overall, HMOs appear to achieve cost savings of 10 to 30%, compared with traditional health care.

Acceptability to the public is shown by the fact that some 900,000 individuals are now enrolled in HMOs that were started since 1971. Cost containment has also been shown by new studies of plans serving

Medicaid recipients in Washington, D. C. and Washington State, and of plans serving Medicare beneficiaries across the country. As you can see on Chart II, these savings are substantial. To give an explicit example, Federal, State and private payments to HMOs for health care to Medicare, Medicaid and Federal employee enrollees amounted to \$276 million in fiscal year 1974 (see Chart III). Assuming savings at the 20 percent level, we estimate that \$55 million was saved compared to the cost of traditional care.

Of course, such cost containment is of no value unless quality services are rendered. One measure of quality is the appropriate control of surgical procedures. Available data as shown on Chart IV demonstrate that HMOs practice surgery at rates substantially below traditional practice, and instead apply appropriate medical care, usually on an ambulatory basis.

In the years since 1970, enrollment in HMOs has grown from 3,600,000 to 5,850,000. The last year has seen an 11 percent increase in HMO enrollment. The number of prepaid plans has grown from 33 in 1970 to about 170 today. But the overall rate of increase is down since the Act was passed .

Chart V shows clearly the increase in numbers of HMO's and enrollees, which has accelerated sharply during this decade. The map (Chart VI) shows the distribution of currently operating "HMOs." Seven of these have been determined to be qualified under the Act.

Establishing additional numbers of this alternative form of health care delivery can result in a wider range of health care alternatives to respond to the demand for health services. We believe that the Federal role should be one limited to five years in order to support demonstrations of HMOs through financial and other support and that the HMO movement should grow in competition with alternative financing and delivery systems through consumer choice without large Federal subsidies. S. 1926, with the modifications and funding levels I am proposing, will permit an adequate Federal demonstration effort.

Implementation of the HMO Act

I would like to review the progress of the Federal assistance to health maintenance organizations, now that it has completed its first full year of operation from June 1974 when a supplemental appropriation to implement the Act was enacted.

1. Grant selection criteria, reporting requirements, and procedures necessary to operate the program have been developed and are in use.
2. Regulations necessary to implement the funding authorities of the Act have been developed and published. Final versions of the complex regulations dealing with the qualification of HMOs and with the far reaching issues associated with the mandatory offer by employers of the HMO option have been issued.
3. A total of 375 applications for \$59 million in grant funds have been evaluated according to established selection criteria and procedures, resulting in the award of 172 grants to 157 organizations totaling \$22.5 million. In all

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there were 104 feasibility grants, 22 planning and 31 initial development grants active at the end of FY 1975. Awards have been made in 38 States, the District of Columbia and the Trust Territory of the Pacific Islands. The geographic Distribution of these projects can be seen from the map on Chart VII. The response to statutory priorities for service to nonmetropolitan and medically underserved areas, as shown in Chart VIII is below our target but we have attempted to establish as many projects as possible in these areas, within the overall requirement that such projects be fiscally viable. A recent independent study of rural HMO-type plans provides a detailed explanation of the difficulty involved in developing qualified rural HMOs under the present Act.

4. Even before formal procedures were instituted, five HMOs were qualified under the Act, four of which are now in full operation. An additional 3 HMOs have been qualified within the past month and 11 applications are currently under review. Ninety-five (95) organizations have signified in writing their intent to submit

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qualification applications. Loans totaling \$4.5 million have been made to 3 of these. A fourth loan action will be completed soon. Eight loan actions are now pending which will involve the commitment of \$8.2 million if all are approved.

5. Technical assistance has been provided to 27 States in the development of HMO enabling acts--25 States now have such legislation--and in the development of procedures for contracting with HMOs to provide health care services to Medicaid recipients. For example, substantial assistance was given to Texas by Regional and Central HMO staff, supplemented by consultants provided by the Department, in the development of a State enabling act. This assistance encompassed the full range of activity from evolution of the statutory language through finalization of the implementing regulations. Maryland received similar assistance. Michigan requested and received assistance in the review by HMO staff of regulations implementing State legislation.

At present, 13 States and the District of Columbia have Medicaid HMO contracts and 10 other States are being assisted by HEW in this regard. Information on the HMO concept and the provisions of the Act has been made available to providers, industry, labor and community groups at numerous meetings.

5. The Department published final regulations on May 9 of this year setting standards for HMO's serving Medicaid recipients. The specifications cover services, enrollment requirements, marketing practices, quality assurance, and many other provisions. The regulations also provide for prior approval by HEW of large contractors.

Draft guidelines to assist States to implement these new standards have been circulated to headquarters and regional HEW staff. The revised draft will soon be circulated to the States for comment before being published.

A proposal by the State of California for a demonstration grant of approximately \$6 million (under the authority of Section 222 of P.L. 92-603) to develop a model State rate setting and monitoring system for HMOs under Medicaid is in the final review process.

7. In addition, the Department has published proposed regulations setting forth procedures to be followed by HMOs in enrolling and disenrolling Medicare beneficiaries and handling grievances, complaints, and appeals of its Medicare enrollees; it has also published proposed regulations which set forth procedures to be followed by HMOs in appealing nonrenewal notices.
8. Finally, we have improved the administration of the program by drawing together into a single operating entity all of the functions relative to HMOs within the Department, except for the certification activity. This operating entity is designated as the Division of Health Maintenance Organizations and is part of the Bureau of Medical Services within the Health Services Administration. The restructuring of the HMO program recognizes the need to continue separation of responsibility for developing HMOs from the responsibility for regulating them, in order to avoid a conflict of interest. Also, in the interest of strengthening our regional

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capacity to serve potential HMO investors, I am considering how we will allocate an additional 10 positions to the program.

Problems within the HMO Act

After a little more than a year of full implementation of the Act, it is clear that certain provisions within the Act will hinder the developing HMOs from achieving the high standard of excellence established by the prototype plans. Several of the 104 grantees receiving funds for feasibility surveys will probably conclude that further development of their programs is not feasible due to the cumulative effect of these provisions. The problem is particularly acute in the Southwest, Southeast and other areas where health insurance premiums and wages are low. HMOs have difficulty competing, given the requirements of existing law.

During this past year, participation of existing prepaid plans and well-established provider groups in program implementation was less than had been expected.

One problem results from a requirement that for an HMO providing services through a medical group practice to be qualified, 51 percent of that group's activity must be devoted to service to HMO enrollees. This effectively prevents large fee-for-service group practices, such as St. Louis Park Clinic and Palo Alto Medical Clinic, from qualifying.

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In addition, an independent study confirmed early impressions that these organizations were concerned about their ability to compete effectively in the health care marketplace if they were required to operate in compliance with all the provisions of P.L. 93-222. This concern stems directly from the combined cost impact of the mandated benefits, open enrollment and community rating.

- HMO's are required to offer a benefit package that is considerably more comprehensive than the benefit package of most insurance plans.
- HMOs must once a year open their enrollment to anyone in the community, including very high risk persons. (The Secretary of HEW may waive this requirement for individual HMOs whose financial viability would be endangered.) In contrast, private carriers may elect whom to enroll, or apply various restrictions to coverage.
- HMOs must community rate, i.e., they must charge essentially the same per person or per family premium for all enrollees regardless of their medical history. In contrast, insurance companies may relate premiums to anticipated use of medical services.

Many specific data are available on the price competition problems of the qualified HMO. At this time I will summarize those points which I believe to be key to the need for the amendments which are being considered today.

Chart IX, based on the analysis of most widely held, most comprehensive Blue Cross, Blue Shield contracts in the Middle Atlantic States (Employee Benefit Plan Review Research Reports 1975) lists the differences in benefits between these health insurance plans and HMOs which allow the former to target their marketing to the best possible price advantage. No single advantage is crucial; it is the flexibility to select the most favorable combinations of benefits, pricing and underwriting policies that provides a substantial competitive edge to the insurance plans.

Turning then to the dollar impact of the competition, typical choices among plans which might be presented to a potential enrollee are listed in Chart X. These averages and ranges are based on data from over 605 employers in 17 cities, results of feasibility and

planning grantees' marketing surveys, data from a nationwide survey of HMO-type plans and an independent study by the General Research Corporation of health insurance provided by major employers in 9 cities. The data shows that 77 percent of the 605 firms had health benefits which cost \$20-57. Most of the basic benefit rates of organizations applying for qualification estimate basic benefits at \$70.00 or more for a family.

It can be argued that a proper understanding of the overall value received for premiums paid to an HMO should suffice to convince a prospect to join the qualified HMO--but more dollars deducted from the paycheck or lower take home pay often are more influential. The amendments before you would help bring the HMO price down to a more competitive range.

One example illustrates the employer contribution factor. State employees have traditionally been major subscribers to HMO plans. Those employees, for the most part, contribute more than half the cost of their health benefits (Chart XI). For a California State employee to enroll in a qualified HMO at \$75 per family per month, that employee's contribution would have to be increased from \$43 to \$59, or by \$16.00, a 38 percent increase beyond his present contribution. Such differentials

clearly inhibit enrollment in HMOs, and need to be minimized since the Act does not require employers to contribute any more than they currently pay for health benefits.

Department Position on S. 1926

With respect to the specific modifications proposed by S. 1926, the Department concurs in the following provisions:

- deletion of the requirement for an annual open enrollment period (Section 4);
- transfer of the medical treatment and referral services for the abuse of or addiction to drugs and alcohol, home health services, and the children's preventive dental benefit from basic benefits to the supplemental service category and the redefinition of preventive health services (Sections 5(a)(1)-(4));
- participation by other health professionals in addition to those kinds previously authorized (Section 5(a)(5));
- removal of the requirement that the members of a "medical group" which contracts with an HMO must have as their principle professional activity the provision of services to an HMO (Section 7);

- expansion of the authority to use loan guarantees for HMO planning, development and operating deficits (Section 8);
- provision to permit more effective use of the loan authorities with the added recommendations (1) that the limitation in the Act on loan guarantees to an amount not to exceed grants and contracts be deleted because the Impoundment Control Act of 1974 addresses the problems envisaged, and (2) that the interest rate for direct loans be the same as that for guaranteed loans (Section 9); and
- provision for mandatory offering of the HMO option to employees only if at least 25 employees reside within the service area of the HMO with the enforcement modifications that I will discuss below (Section 10).

Recommended Modifications to S. 1926

We feel that if an HMO receives the benefits of the Act, in terms either of financial aid or of certification under the "dual choice" option, it should be required to furnish the important health services listed in the

Act as supplemental services if the manpower is available and if the recipient desires those services. Therefore, we believe that it would be beneficial to delete Section 2 which would make the offering of supplemental health services by HMOs no longer mandatory. We suggest instead that HMO's be given an option to redesignate any supplemental benefits as part of the basic benefits package it offers to prospective members, as has been done in H.R. 9019. This is because some HMO's may wish to offer more benefits as basic services than those specified in the Act, and the Act can now be interpreted as prohibiting additional basic services.

Section 3 would expand the options available to HMO's to arrange for the provision of services to its members. While we would agree that an HMO should have more flexibility in making arrangements for the delivery of health services to its members, nevertheless we object to any proposal to extend that policy to the extreme of dealing with individual practitioners. In our view it is important for HMO's to deal with providers as groups.

Section 6 of the bill proposes to delay the community rating requirement for basic and supplemental health services for five years with the assurance that an HMO so exempted will employ a community rating program at that time.

We are in agreement with the objectives of the provision; however, we strongly believe that there should be no statutory provision which specifies the criteria and method of rate setting. Requiring HMO's to community rate when private insurance companies can use experience rating is inequitable and we urge deletion of this provision from existing law.

Section 10 would charge this Department with enforcement of the "dual choice" provisions of the HMO Act and spell out detailed enforcement procedures including a \$10,000 civil penalty for noncompliance. It is not the mission of this Department to enforce civil penalties, and the resources needed to carry out such enforcement would only detract from the implementation of other important program functions. Therefore, we propose a change that would simply levy a \$5,000 civil penalty for noncompliance with the "dual choice" option and would leave the procedures and enforcement of this provision to the usual mechanism of the Department of Justice.

We suggest that the provision (Section 11) concerned with the procedure for decertification of HMOs in respect to the dual choice option be deleted because it is unnecessary; it would be more appropriate for such detailed procedure to be spelled out in regulations.

In addition, we feel that there is no compelling reason to require an entity to be subject to Federal regulation under title XIII of the PHS Act if it is willing to forego all the benefits of that title and repay, with interest, funds it has received under that title. We propose that HMOs subject to title XIII be released from further regulation (presently required in perpetuity) after twenty years, or earlier if they paid back, with interest, funds they have received under that title, but that they consequently lose all benefits under the law, including certification for dual choice.

We recommend that the extension provisions of Section 13 be substituted by a one-year extension of authority to award grants and contracts for feasibility, planning, development, and initial operation and loan and loan guarantees. A one-year extension of these authorities will accomplish the Administration's original goal of

a limited five-year demonstration of the HMO concept. In addition, we oppose the appropriation authorizations in Section 13 and recommend instead authorizations of \$18 million for FY 1976, FY 1977, and FY 1978. This is consistent with the level in the President's FY 1976 budget.

We have an additional recommendation, Mr. Chairman. Section 1310 of the Public Health Service Act requires certain employers to include in any health benefits plan offered to their employees the option of membership in a health maintenance organization. "Employer" is defined by reference to the Fair Labor Standards Act. Because that Act has generated substantial litigation over the meaning of the term "employer," we believe that it is undesirable to define employer in Section 1310 by reference to the Fair Labor Standards Act. A more general, independent definition, based on language in the National Labor Relations Act and the Labor-Management Relations Act, 1947, would reduce the possibility of litigation over distinctions not important in a health context and eliminate possible difficulties inherent in involving two agencies in the interpretation of the same complex law.

H.R. 9019

My remarks on S. 1926 apply to the similar provisions in H.R. 9019. In addition, with respect to that bill, I have several particular comments.

As I have indicated previously, one of the administrative improvements we have made as a result of our experience with the program and in response to concerns expressed in House Committee Report 94-518 has been a reorganization of the operational HMO offices within the Department. I expect these changes to facilitate program administration and believe they satisfy the intent of the amendment of H.R. 9019 which would require administering the HMO program through a "single identifiable administrative unit." Nevertheless, I believe the amendment should be deleted not only because it is restrictive, but because it would result in creating a conflict of program interests by combining the development of HMOs with the regulation of HMOs. Further, the Secretary and I firmly believe that we should be permitted to administer Departmental health programs in the manner we deem most effective.

Similarly, the present requirement that continuing regulation of HMOs be administered in the Office of the Assistant Secretary for Health should be deleted.

We endorse the clarification of existing law which provides that an employer offer an HMO option under "dual choice" first to the employees' representative, if any, and, if accepted by the representative, then to the individual employees. Under present law and regulations, if an employer who is subject to the requirement offers the options to a collective bargaining agent representing the employees, and the agent refuses, the employer's obligation would be satisfied. However, if the agent accepts, the agent could also elect HMO participation for the employees represented. This amendment would assure that each individual employee chooses to participate before joining.

Conclusion

Mr. Chairman, at the risk of singling out issues for special attention, I must nevertheless state in closing that in our view the critical issues on HMO development relate to the dual choice and qualification provisions. These provisions should be intended to allow HMOs to compete on an equal footing and without Federal subsidy. HMOs simply cannot be expected to be the vehicle for solving the basic benefit package and coverage problems--particularly for high risk groups--of our society. This concept is particularly important in light of the retention--albeit with a five-year deferral--of the community rating provision in the bill you are considering.

In general, we believe that the administrative groundwork for a solid base of HMO demonstration has been laid, and with a limited one year extension and funding of \$18 million annually and with appropriate amendments, as discussed above, this effort can accomplish its original objectives.

Mr. Chairman, this concludes my statement. My colleagues and I will be pleased to try to answer any questions which you or the other members of the Subcommittee may have.

HMO GOALS AND OBJECTIVES**THE HMO PRACTICES:**

- AMBULATORY AND PREVENTIVE SERVICES, PRIMARILY
- INPATIENT CARE ONLY WHEN MEDICALLY NECESSARY

TO ACHIEVE:

- HIGH QUALITY SERVICES
- COST CONTAINMENT

	ESTABLISHED "HMO'S"	RECENTLY FORMED "HMO'S"
INPATIENT DAYS PER 1,000 HMO MEMBERS	450	395
INPATIENT DAYS PER 1,000 CONTROL POPULATION	950	810
PERCENT SAVINGS OF HMO PLANS OVER TRADITIONAL HEALTH CARE	53	51

HMO COST CONTAINMENT**SUMMARY OF DATA FOR PRE-HMO ACT PLANS**

<u>SOURCE OF DATA</u>	<u>PERCENT SAVINGS COMPARED TO CONTROL POPULATION</u>
MEDICARE	12
MEDICAID	
GROUP HEALTH ASSOCIATION OF WASHINGTON, D.C.	21
GROUP HEALTH COOPERATIVE OF PUGET SOUND	30
WAUSAU STUDY	21
ROEMER STUDY	10 - 20

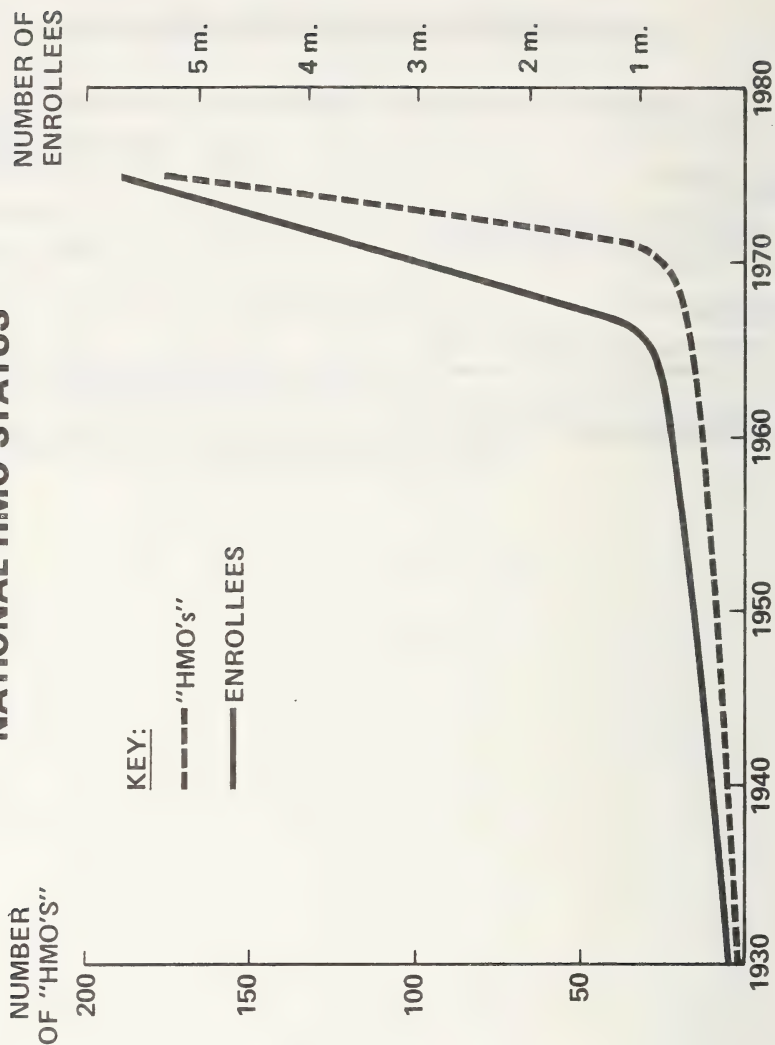
FEDERAL/STATE PURCHASE OF HMO SERVICES

<u>PROGRAM</u>	<u>HMO ENROLLEES (1974 DATA)</u>
MEDICARE	379,000
MEDICAID	300,000
FEHBP	550,000
TOTAL ENROLLEES	1,229,000
TOTAL COST OF HMO SERVICES, PAID BY FEDERAL AND STATE GOVERNMENTS AND ENROLLEES	\$276,000,000
ESTIMATED SAVINGS OVER TRADITIONAL SERVICES FOR SAME POPULATION (20% OF HMO SERVICE COSTS)	\$ 55,200,000

HMO IMPACT ON QUALITY OF CARE**SURGERY PERFORMED ONLY WHEN MEDICALLY NECESSARY**

	<u>HMO</u>	<u>OTHER PROVIDERS</u>
<u>1960 DATA</u>		
HOSPITALIZED SURGICAL CASES PER 1,000 PERSONS PER YEAR	49	60
<u>1975 DATA</u>		
HOSPITALIZED SURGICAL CASES PER 1,000 PERSONS PER YEAR	54	90
MEDICAID ADMISSIONS FOR SURGERY PER 1,000 PERSONS PER YEAR	18	33

NATIONAL HMO STATUS



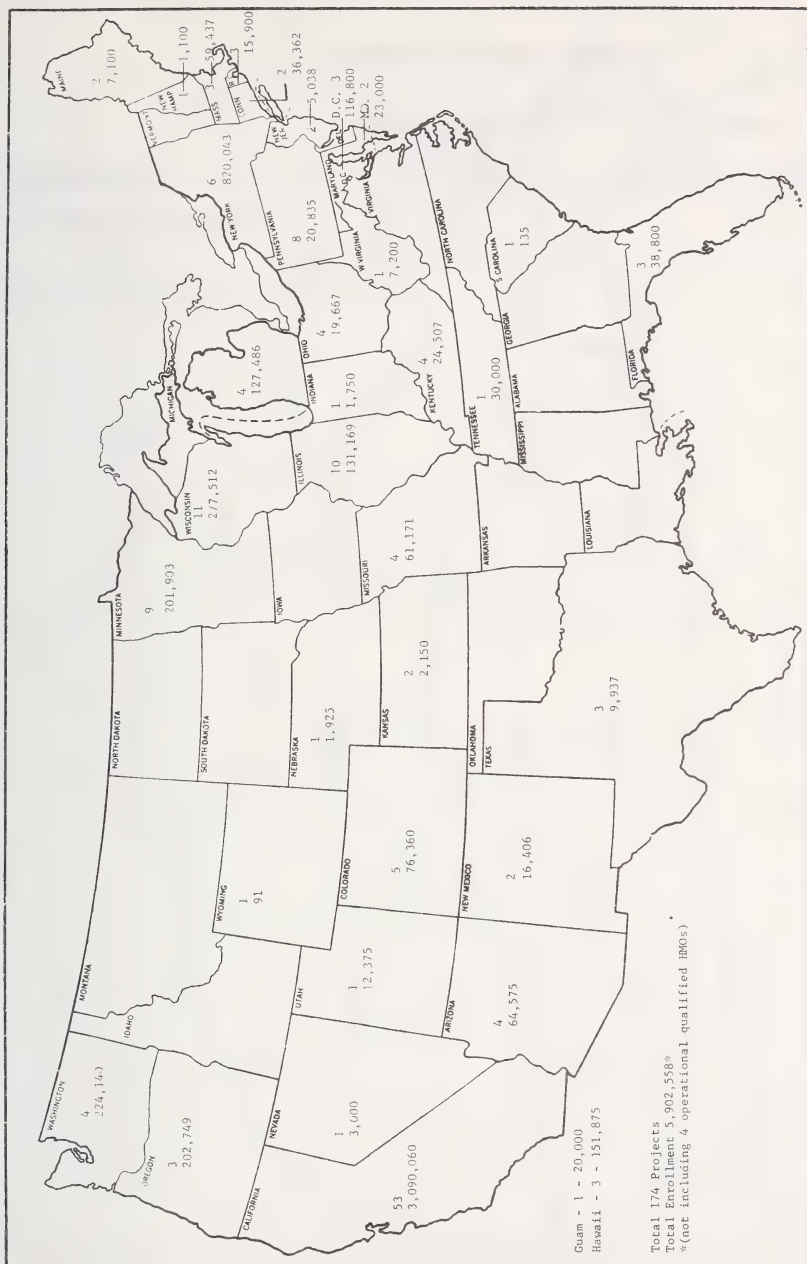
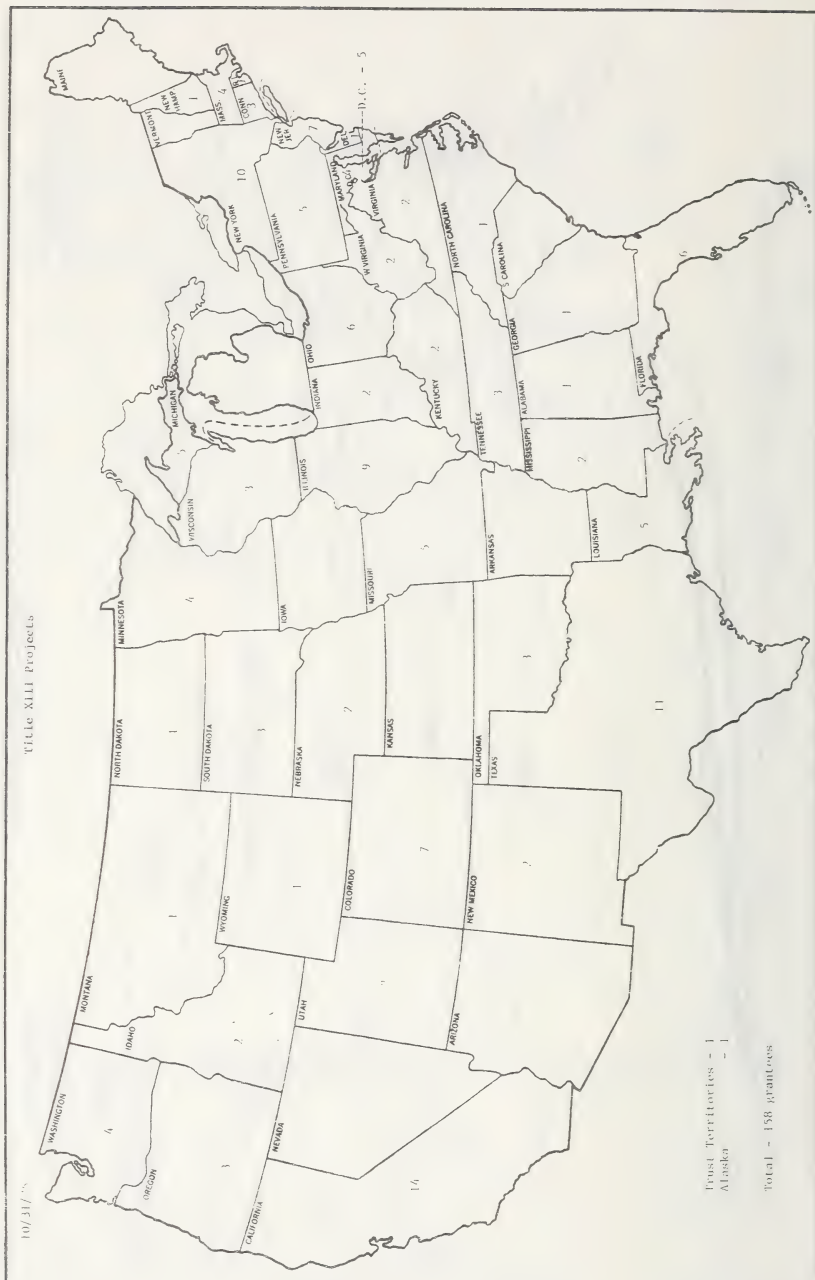


CHART VII



STATUTORY PRIORITIES UNDER TITLE XIII

PROJECTS SERVING	PROJECTS FUNDED		AWARDS	
	<u>NUMBER</u>	<u>PERCENT</u>	<u>DOLLARS (IN MILLIONS)</u>	<u>PERCENT</u>
NONMETROPOLITAN AREAS	31	18	\$2.6	11.5
MEDICALLY UNDERSERVED AREAS	25	14.5	1.8	8.1

FEDERAL HMO BENEFIT REQUIREMENTS

HMO ACT BASIC BENEFITS EXCEED BENEFITS OF TYPICAL INSURANCE PLANS.

- ALMOST ALL INSURANCE PLANS CONTAIN:
 - LIMITATIONS
 - EXCLUSIONS
 - WAITING PERIODS
 - DEDUCTIBLES AND COINSURANCE
- INSURANCE PLANS ARE:
 - EXPERIENCE-RATED
 - NOT SUBJECT TO OPEN ENROLLMENT
- BROAD BENEFITS PACKAGE, COMMUNITY RATING, AND ENROLLMENT REQUIREMENTS IN HMO ACT PLACE FEDERAL HMO's AT A COMPETITIVE DISADVANTAGE.

COMPETITIVENESS OF QUALIFIED HMO'S**PRICE COMPARISONS OF HMO AND INSURANCE PLANS**

	<u>MONTHLY FAMILY PREMIUM</u>	<u>RANGE OF FAMILY PREMIUMS</u>
FEDERALLY MANDATED HMO BENEFIT PACKAGE	\$75	\$57 - 90
TYPICAL OPERATING HMO	60	39 - 82
TYPICAL BLUE CROSS/BLUE SHIELD PLAN	53	45 - 65
TYPICAL INDEMNITY PLAN	48	21 - 82

STATE GOVERNMENT EMPLOYEE HEALTH PLAN COSTS

HMO MUST BE COMPETITIVE IN STATE EMPLOYMENT MARKET

SEGAL STUDY

- 65 PERCENT OF PRIVATE EMPLOYERS PAY FULL COST OF INSURANCE.
- 60 PERCENT OF STATE PLANS REQUIRE EMPLOYEE CONTRIBUTIONS OF GREATER THAN ONE HALF.

	<u>MONTHLY EMPLOYEE PAYMENT</u>	<u>MONTHLY STATE PAYMENT</u>	<u>TOTAL</u>
ILLINOIS	\$35	\$23	\$58
CALIFORNIA	43	16	59
MARYLAND	32	27	59

Statement Submitted to

Subcommittee on Health

Committee on Labor and Public Welfare

United States Senate

By

NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

2233 Wisconsin Avenue, N.W.

Washington, D.C. 20007

Concerning

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1975

S 1926

November 12, 1975

This statement is presented on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 317 community mental health centers, most of which receive federal funding under the Community Mental Health Centers Act, and another 119 agencies which are developing CMHC programs or which have a direct interest in community mental health.

NCCMHC has taken a strong interest in the development of health maintenance organizations, and particularly the federal initiative to stimulate development of new HMO programs which was heralded as an important step in improving the delivery system prior to the enactment of national health insurance.

HMOs which provide a full range of services to a defined population (its enrollees) can indeed have a major impact in bringing comprehensive services to populations now without adequate care, while at the same time emphasizing prevention and health maintenance.

As this committee is fully aware, the network of federally-funded community mental health centers has similar goals: to provide comprehensive mental health services to specified populations emphasizing prevention. The services provided, either directly or through contract arrangements with other agencies, are designed to meet all of the mental health needs of the catchment area -- from preventive care, inpatient and outpatient services to the important new services to be required under PL 94-63, children's services, geriatrics programs, aftercare and screening of individuals being considered for admission to state institutions.

The federal government has also supported other programs to develop systems of care, such as the neighborhood health centers. However, whereas the requirements for comprehensive services provided by both CMHCs and community health centers would be expanded under PL 94-63, the Committee is now considering legislation to reduce the benefits available to HMO enrollees.

If the federal government intends to encourage the initiation of new health service delivery programs such as HMOs, it is extremely important that these new programs be comprehensive. There are already a substantial number of HMO-type organizations which have been initiated without federal funding and which are less than comprehensive. These organizations are doing well without federal assistance. For the substantial investment of federal dollars which the HMO legislation would provide to each entity, the federal government has the right to expect some changes and improvements in the availability and accessibility of health care services. Moreover, at this time it is clear that national health insurance, while not immediately imminent, is likely to be enacted within the next several years. Indeed, part of the rationale for the HMO program was to strengthen the delivery system and build in cost-effective mechanisms for health care delivery prior to enactment of NHI. All of the major NHI bills recognize the validity of the HMO concept, and would provide funding to enable services to be provided in such a setting. Hence, the question of non-competitiveness of the HMO becomes moot once NHI is enacted.

We believe the success of the CMHC program, and the fact that a number of centers (although by no means all of them) will be able to operate fully comprehensive programs once their federal grants run out, is evidence that the initiation of complete systems of health care by the federal government is both viable and highly effective in bringing services to those previously without adequate care. The concept that the recipients of federal funds have an obligation to help address national problems is well established in legislation prepared by this committee in recent years: the health services bill (PL 94-63), health manpower bill and health planning legislation. This concept seemed also to be clearly established in the HMO legislation.

S 1926, however, would make a number of major changes in the HMO Act; changes which in effect alter the purpose and meaning of the legislation.

This bill would eliminate much of the obligation of the HMO receiving federal aid to address the vital issues of accessibility of services to all in need, and the availability of fully comprehensive services to which the patient would have access via his own, primary physician.

S 1926 would amend the current law to eliminate the requirement that the HMO have an open enrollment period during which time it accepts all individuals, regardless of their past health condition or any other factor. This amendment would effectively eliminate the role of the HMO in providing services to those individuals who now are unable to obtain health care coverage, those who for various reasons are medically underserved. This change is designed to make the HMO "competitive" with other health care insurers which operate in the market, which receive no direct federal funding, and which have also failed to solve the problems of accessibility and maldistribution of services.

If the federal government is to invest substantially in HMOs, it has the right to expect that individuals now unable to find or pay for the treatment they require will receive services as a result of this investment.

The elimination of the open enrollment period also permits the HMOs to discriminate against certain individuals, and in all probability could lead to discrimination against those with previous histories of, for instance, mental illness. Historically, mental health services have been discriminated against in health insurance plans, the early proto-type HMOs and similar organizations. Elimination of the open enrollment period is an invitation for continued discrimination against those with a past-history of mental illness as well as other pre-existing conditions.

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Once again, programs which receive federal assistance have some responsibility to meet the health care needs of those individuals who are generally excluded from our present system.

S 1926 also reduces the comprehensiveness of the services which would be required -- eliminating the very important service of medical treatment and referral services for the abuse of or addiction to alcohol or drugs. Coupled with this change is a proposed alteration in the language regarding supplemental services which removes the patient's option to choose to pay for coverage of supplemental services and enables the HMO instead to decide whether or not it will offer the patient these additional services, for an additional capitation payment.

As a result, the list of supplemental services in this legislation would give only the appearance of comprehensiveness. In fact, given the general opposition among HMOs to fully comprehensive services it is extremely unlikely that any supplemental services will be offered by most HMOs under the terms of S 1926. And even if the patient would like this coverage and is willing to pay for it, it will not be available to him.

Since the mental health services required as basic services are defined as "short term (not to exceed 20 visits) evaluative and crisis intervention" services, and since other mental health services are supplementary services, this language would have the effect of eliminating the patient's option to obtain full coverage for mental health care. HMOs would be free to eliminate all but the basic 20 outpatient visits from their mental health services. NCCMHC strongly objects to such a change. Approximately one in ten Americans are believed to need mental health care during their lifetime, and mental and emotional illness and stress are clearly interrelated with other diseases and illnesses. Coverage of mental health services is economically feasible, as shown by a number of health insurance plans which provide extensive coverage of mental health services. Appended to this statement is a summary of the data from such plans, which clearly shows that the costs of such coverage are reasonable, and that utilization is not excessive.

NCCMHC urges that all HMOs be required to continue to offer supplementary services to those individuals who are willing to pay an additional capitation payment for such coverage.

The elimination of alcohol and drug abuse services from the list of basic services is extremely inappropriate. Alcoholism is a major social disease at this time, with an estimated 9 million victims. Drug abuse is still a serious problem in many communities. The services required under the previous legislation are well within the scope of most HMOs -- medical treatment for individuals who need immediate assistance, and referral services to specialized treatment programs within the community. The HMOs are not required to provide comprehensive programs for alcoholics and drug abusers -- including detoxification, treatment and rehabilitation -- as, for instance, CMHCs are required to do, but to ensure that their patients have access to such services outside the HMO. NCCMHC believes that this is a minimum requirement and that this service should remain a part of the basic, required services for all federally-funded HMOs.

Finally, NCCMHC would like to propose an amendment to the HMO Act to reinstate the language which was contained in the Senate bill of the original HMO legislation so as to require that in providing mental health services the HMO utilize existing community mental health centers on a priority basis.

This language was not contained in the House bill, but the House report (H Rept. 93-451) made clear the Committee's intent that HMOs work with CMHCs wherever possible and feasible, in order to ensure that services were not being duplicated:

"Where a comprehensive community mental health center is, or plans to be, serving the same population as the HMO it would be desirable for the mental health services to be provided by, or in cooperation with, that community mental health center. The community mental health centers program, which places considerable emphasis on preventive consultation and education services, is highly compatible with the HMO concept. The current network of approximately 500 federally-funded community mental health centers offers a unique system of comprehensive care for the mentally ill, and the Committee feels that HMOs should not attempt to duplicate these services if they are already available in the community. Arrangements for provision of mental health care through community mental health centers might be based on formal contract or affiliation agreements, or on more informal referral arrangements depending upon the particular situation...Such arrangements can greatly strengthen the system of health care delivery in this country and...cooperative arrangements are desirable as new HMOs are formed."

The conference report on this bill, however, failed to include any language encouraging the use of CMHCs. And although the proposed HEW draft regulations for HMOs encouraged the utilization of CMHCs on a priority basis and cooperation between the federally funded CMHCs and the federally funded HMOs where similar services were to be provided to the same community, this language was dropped in the final regulations as a result of pressure from HMO groups.

NCCMHC believes that the federal government cannot afford to fund similar services in two different programs which serve the same population. Where a CMHC is now established, or about to be initiated it makes no sense for an HMO to set up its own mental health program. The CMHC Amendments of 1975 (PL 94-63) recognize this fact by requiring that CMHCs work wherever possible with HMOs in their area. A similar and complementary requirement of the HMO is now needed to ensure that this working relationship does in fact develop.

In conclusion, NCCMHC urges that the Committee not adopt the sections of S 1926 cited above (Sec. 2, 4, and 5) regarding the dropping from the basic services of alcohol and drug abuse services, the change to make supplementary services optional at the HMO's discretion, and the elimination of the requirement for an open enrollment period during which time individuals will be accepted, regardless of previous health conditions.

In addition, NCCMHC urges an amendment to Sec. 1302 of the HMO Act, so as to restore the language of the Senate version of the original bill to require that HMOs provide:

"(D) short-term (not to exceed twenty visits) outpatient evaluative and crisis intervention mental health services, utilizing existing community mental health centers on a priority basis"

APPENDIX

THE COSTS OF
COVERAGE OF MENTAL HEALTH CARE UNDER INSURANCE PROGRAMS

With a new emphasis on community based treatment, particularly outpatient and other services which are less intensive than 24 hour inpatient care, the feasibility of covering mental health services under health insurance programs has increased.

A study by Louis S. Reed, to be published shortly by the American Psychiatric Association* includes data from several health insurance plans which indicate the feasibility in terms of costs of covering extensive mental health services, particularly outpatient care and other alternatives to hospitalization. Cited below are data from this study, which reviewed the following plans:

- Federal Employee Blue Cross/Blue Shield High Option Plan
- United Auto Workers health insurance plan
- Canadian Health Insurance System

Blue Cross/Blue Shield for Federal Employees: Considerable data is now available on the federal employees high option plan, which covers about 4.5 million people and is the largest private health insurance plan in the world. This plan provides extensive benefits: full coverage for 365 days per admission is provided for hospital care; physicians' in-hospital charges are covered in full; under supplemental benefits the plan pays 80% of physicians outpatient charges, subject to a \$100 deductible.

As the high option plan for mental health benefits was initiated, utilization rates increased. This could be expected in any program as new benefits are added. However, over recent years the rate of utilization has stabilized at around 7% of all benefits under the plan. (See table below)

FEDERAL EMPLOYEES HEALTH BENEFIT PLAN -- BLUE CROSS/BLUE SHIELD
BASIC BENEFITS, HIGH AND LOW OPTIONS COMBINED

	<u>Benefits Paid for Mental Disorders</u>	<u>Total Benefits Paid</u>	<u>Percent</u>
1960-65	\$40.2	\$1,040.4	3.9
1966	13.2	277.2	4.8
1967	18.1	336.8	5.4
1968	24.8	405.0	6.1
1969	30.4	480.9	6.3
1970	41.1	601.9	6.8
1971	49.1	698.9	7.0
1972	54.3	760.4	7.1
1973	61.6	848.2	7.3
1974	70.1	979.1	7.2

SOURCE: Office of the Actuary, U.S. Civil Service Commission (9/12/74).

Data from this plan also reveal that 80% of persons receiving inpatient care for nervous and mental disorders were released within 30 days, and accounted for 45% of the total charges. The 89% who were released within 45 days accounted for 62% of charges, the 97% released within 90 days accounted for 84% of charges and the 99% released within 120 days accounted for 91% of the charges.

* Louis S. Reed, "Coverage and Utilization of Care of Mental Conditions Under Health Insurance: Various Studies", in press, American Psychiatric Association, 1975.

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With regard to outpatient care, in 1973 persons with claims for mental illness constituted 0.6% of the total covered population. Of all persons incurring mental health charges, 62.2% had charges of less than \$400 and their charges amounted to 15.3% of the total. Another 28.5% had charges of between \$500 and \$1,999, their charges amounting to 38.3% of the total. Another 7.2% had charges between \$2,000 and \$5,000 during the year, their charges amounting to 29.1% of the total. Finally, 2% had charges of over \$5,000, amounting to 17.4% of the total.

UAW Plan: The United Auto Workers plan provides up to \$400 a person a year in outpatient mental health coverage, and 45 days of inpatient care. There are no deductibles, and provided the patient receives care from an accredited group facility there is no copayment.

A recent study of utilization of UAW members in Baltimore,* shows the cost per enrollee increased from \$2.71 in 1967 to \$5.41 in 1970, but was less than 50¢ per enrollee per month.

The study compared utilization rates between those who visited a private practitioner and those who visited the Johns Hopkins clinic. The hospitalization rate was much higher among the patients seen through fee-for-service financing (52% of patients) compared with those using the clinic (4%).

Canadian Health Insurance Programs: The Reed study included a review of the Canadian federal-provincial programs of hospital and medical insurance, which provide care for mental conditions to the same extent as for other conditions.

In 1971, hospital separations with a diagnosis of mental illness comprised 3.7% of all separations, and patient days for mental illness were 5.7% of days for all conditions.

In 1971, 1972 and 1973, payments for outpatient psychiatric services ranged from 43¢ to \$3.15 per covered person and constituted 1.4% to 5.4% of total payments for all medical services.

Finally, the Reed study shows the extent to which employees in a cross section of American industry are covered for mental illness under their employee health plans.

Data provided by the Department of Labor's Digest of Selected Health and Insurance Plans, shows in 1974, that 68% of plans studied provided the same hospital benefits for mental conditions as for other conditions, the remaining 32% had reduced benefits. 41% of the plans provided the same outpatient care, 45% had reduced benefits for mental conditions, 8% had no outpatient coverage for either mental or other conditions and 5% provided greater benefits for mental than other conditions.

Other data on costs of inpatient and outpatient mental health care under a wide range of plans are shown in the following tables extracted from Health Insurance and Psychiatric Care: Utilization and Cost**

* H. R. Spiro, G. M. Crocettie and I. Siassi: "Fee-for-Service Insurance versus Cost Financing: Impact on Mental Health Care Systems", American Journal of Public Health 65: 139-143, February 1975.

** L. S. Reed, E. S. Myer, and P. L. Scheidemandel: Health Insurance and Psychiatric Care: Utilization and Cost. American Psychiatric Association, Washington, D.C. 1972

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HOSPITAL CARE FOR MENTAL ILLNESS -- COST RATES BY BENEFIT PERIOD, 1968-1969

Benefit Period	Cost per covered person (mental illness)	Percent of cost for all conditions	Average length of stay (mental)
<u>Less than 30 days</u>			
GHI (NY) Federal, Low Option (10 days)	\$0.34	0.8%	4.3
Group Health Assn. Federal (10 days +)	0.65	1.2	12.5
Kaiser Hawaii (20 days)	0.74	2.3	2.7
N.Y. City Blue Cross (21 days + 9 half days)	1.47	3.0	16.3
<u>30-31 days</u>			
Hawaii Medical Service, Federal	0.40	1.1	7.9
Tennessee Blue Cross	0.89	1.6	10.5
Federal Blue Cross-Blue Shield, Low Option	1.11	3.5	10.7
New York (Syracuse) Blue Cross	1.60	3.8	13.4
Postmasters Benefit Plan	1.70	2.2	75.3
GHI (NY) Federal, High Option	1.74	2.6	11.1
Kentucky Blue Cross	1.81	4.2	11.8
Connecticut Blue Cross	1.84	4.4	12.7
Maryland Blue Cross	1.93	3.0	14.1
Western Pennsylvania Blue Cross	1.94	2.8	10.8
Philadelphia Blue Cross	1.98	3.1	15.2
National Assn. of Letter Carriers	2.14	4.2	20.3
National Postal Union	2.18	3.2	15.8
St. Louis Blue Cross	3.42	6.5	14.5
<u>45-50 days</u>			
Kaiser Oregon (45 @ 80%) Federal	0.17	0.5	4.3
Washington Physicians Service (45)	00.89	2.8	7.5
Kaiser Southern California (45)	1.36	3.1	15.4
Mail Handlers (45)	1.73	3.5	17.5
Rural Carriers (45)	1.93	3.7	17.9
United Federation of Postal Clerks (50 days/lifetime)	2.23	3.3	18.9
<u>70 days and over</u>			
HIP Federal, Low Option (70)	1.22	2.5	5.8
Delaware Blue Cross (120)	1.45	3.2	23.6
Ohio (Cincinnati) Blue Cross (70+)	2.64	4.5	16.0
Federal Blue Cross/Blue Shield, High Opt (365)	3.23	5.0	16.3
HIP Federal, High Option (365)	3.43	6.2	24.7
American Federation of Govt. Employees (200)	3.63	4.0	22.6
Virginia Blue Cross (70)	3.96	5.8	18.5
Govt. Employees Hospital Assn. (\$2,000 + 80% thereafter)	5.70	6.9	31.0

COST OF PHYSICIANS' SERVICES FOR MENTAL ILLNESS UNDER PRIVATE HEALTH INSURANCE, 1968-1969

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Plan	Cost Per Covered Person	Percent of Cost of Physicians' Services for all Illness	Benefits for Mental Illness
National Postal Union	\$0.27	1.8%	80% of 1st 10 visits, then 50% to \$400*
Group Health Assn., Transit Workers	0.56	-	\$15/visit to 16 visits/yr. (excl. long-term care)
Postmasters Benefits Plan	0.66	2.3	50%, \$100 deductible*
Hawaii Medical Service, Federal	0.69	1.0	\$300/yr, 1st visit deductible*
Washington Physicians Service, Federal	0.71	-	75% to 20 visits/yr*
Mail Handlers	0.79	9.4	75% to \$300/yr; 20 visits/yr.*
Rural Carriers	0.92	6.8	80% to \$1,500 yr, \$50 deductible*
Group Health Assn., Federal	1.02	-	\$15/visit to 16 visits/yr. (excl. long-term care)
United Federation of Postal Clerks	1.12	5.6	50 visits/lifetime @ \$25
National Assn. of Letter Carriers	1.32	9.3	80% to \$400, then 50% to \$3,000*
Group Health Insurance, Fed., Low Option	1.37	3.5	\$300/yr for adults; \$500/yr for children
Michigan Blue Cross/Blue Shield	1.43	-	1st 5 visits in full; coinsurance
Kaiser Oregon, Federal	1.43	3.5	80% to \$400
Group Health Assn., General Enrollees	1.48	-	\$15/visit to 16 visits/yr. (excl. long-term care)
Group Health Insurance, Fed., High Option	1.66	3.5	\$300/yr for adults; \$500/yr for children
St. Louis Labor Health Institute	1.69	8.0	Unlimited
Maryland Blue Cross/Blue Shield	1.94	-	1st 5 visits in full; coinsurance
Govt. Employees Hospital Assn.	2.32	9.2	30 visits/yr*
American Federation of Govt. Employees	2.40	7.2	50% to 50 visits/yr., \$50 deductible*

* Includes physicians' services in and out of hospital.

(v)

HMO Experience

Studies of group practice organizations demonstrate that mental health services can be provided without utilization rates and costs becoming excessive (5 per cent of HMO premiums for mental health services). Further HMO studies indicate that patients treated by mental health providers reduce their non-psychiatric physician usage within the HMO by a significant percentage and that providing mental health services through the HMO results in savings in subsequent years up to \$240 per case or 20¢ per enrollee per month.**

Conclusion

The cost of mental illness is now conservatively measured as around \$30 billion per annum; the direct cost of services (including the expense of pre-payment through insurance) is \$10.4 billion, equivalent to 14% of all health care expenditures in the nation.

Data indicate the feasibility of covering mental health services under insurance plans without severe restrictions or limitations:

- The costs of essentially unlimited mental health coverage in the Federal Employees Program has plateaued at around 7% of all health benefits
- HMOs estimate five per cent of their premium for the provision of limited mental health services
- In CHAMPUS program, which has been criticized for escalating mental health costs, mh costs constitute 19% of all health benefits (high because CHAMPUS covers care not available in military hospitals, which most prominently excludes mental health services)
- More than two-thirds of the employees in the plans studied by Louis Reed have nondiscriminatory inpatient coverage, and more than two-fifths have nondiscriminatory outpatient coverage -- large groups of American workers clearly already have substantial mental health coverage where utilization rates and costs have not proved to be a problem

** Goldberg, Irving D. et al "Effect of a Short-term Outpatient Psychiatric Therapy Benefit on Utilization of Medicare Services in a Prepaid Group Practice Medical Program" Medicare Care 8:419-428 (September-October 1970) and Follette, William and Cummings, Nicholas A. "Psychiatric Services and Medical Utilization in a Prepaid Health Plan Setting" Medical Care 5: 25-35 (January-February 1967)

A PILOT STUDY COMPARING
THE UTILIZATION AND HEALTH CARE COSTS INCURRED
BY GROUP AND NONGROUP ENROLLEES
OF A PREPAID GROUP PRACTICE

Conducted at
The Marshfield Clinic
Marshfield, Wisconsin

Ingo Angermeier
Spring 1974

TITLE: A PILOT STUDY COMPARING THE UTILIZATION AND HEALTH CARE COSTS INCURRED BY GROUP AND NONGROUP ENROLLEES OF A PREPAID GROUP PRACTICE.

PURPOSE OF THE STUDY: To demonstrate the effects of an open enrollment on the utilization of plan benefits and the cost of providing those benefits; to provide an empirical base line describing the effects of nongroup enrollees for plans contemplating instituting a policy of open enrollment.

METHOD USED: Utilizing the data files of the Clinic, all enrollees of the Greater Marshfield Community Health Plan were categorized according to group and nongroup status. They were then placed into frequency distributions describing outpatient utilization, inpatient utilization, cost of outpatient care, cost of inpatient care, and total health care costs incurred. These distributions were tested to determine whether the observed distributions corresponded to expected experience. A second study similar in structure to the first was undertaken describing only those group and nongroup enrollees with at least six months experience in the plan prior to the study year.

SIGNIFICANT FINDINGS AND CONCLUSIONS: Compared to group enrollees of the total plan, nongroup members have higher utilization and health care costs. The difference in the health care behavior between group and nongroup enrollees with prior experience is less than that of the total plan. It is not prohibitive for the GMCHP to provide benefits to nongroup enrollees.

RECOMMENDATIONS: The GMCHP should continue to practice its policy of open enrollment. This study should be taken as a base line describing one plan's experience with nongroup enrollees and may encourage other plans to consider such a policy.

PREFACE

Many studies have compared the utilization of health services under prepaid group practices to the fee-for-service system. Although the findings of these papers have demonstrated something of the value of prepaid programs, the population served by many such plans is often not comparable to the total population. Recent state and federal legislation is forcing prepaid health plans to offer their benefit packages to a broad range of consumers, irrespective of employment or pre-existing medical conditions.

This study is an attempt to describe the experience of a prepaid group health plan with its open enrollment population. As a pilot study on a young plan, the findings may not apply to health plans other than the Greater Marshfield Community Health Plan.

My gratitude and appreciation are extended to a number of people: James M. Ensign, Executive Director for his encouragement in pursuing this topic and the use of the resources of the Marshfield Clinic; Frederick Wenzel, Executive Director of the Marshfield Clinic Foundation for Medical Research and Education, for his aid and counsel; Dennis Krahn, Senior Systems Analyst-Programmer, for his patience and interpretive skills; Donald Nystrom, Manager of Prepaid Programs; Kathy Parbel, Executive Secretary; and Greg Nycz, Data Comptroller, whose time was always available for needed advice.

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CHAPTER I

INTRODUCTION

A - Background Information

The health care delivery system of the United States has been the subject of increasing scrutiny by health care professionals, public lawmakers, and the consumers of health care. Much dissatisfaction has been expressed over discontinuity of care, inconsistent quality of care, and poor accessibility--all in the face of rapidly rising costs.

The recent development of Health Maintenance Organizations (HMOs) has been hailed by many as the savior of the American health care delivery system. HMOs are generally thought to be organizations contracting directly with consumers to provide a comprehensive package of health care services at a fixed price to the alleged end of maintaining health as opposed to active disease treatment. The number of definitions of what an HMO is and does is matched only by the number of organizations claiming to practice health maintenance.

In spite of their widely varying organizational structures and benefit packages, proponents of HMOs insist on comparing

their utilization rates and hospital inpatient days to both each other and the alternative fee-for-service system. The publications they generate extolling their merits bulge with statistics claiming that emphasis on preventative outpatient care has lowered hospital inpatient utilization to less than half the national average.¹

However, should not the HMO compare utilization rates of like populations for any such comparisons to be valid? Few HMOs allow enrollment for those over 65. Few HMOs provide services to those on Medicaid. Few HMOs open their enrollment to those that are not members of an employee or union group. Most of those that do require physicals to eliminate coverage for pre-existing conditions or require security deposits. While HMOs experience lower rates of hospitalization than the national average, it remains unclear whether they do so as a result of their emphasis on maintenance or as a result of their enrollment selectivity. Until such time as these prepaid group practices can demonstrate their claims of lower utilization and greater cost effectiveness on the population at large, their claims of efficiency will remain questionable.

If current legislation is any indication of lawmakers preferences, prepaid group practices will be increasingly en-

1. I. S. Falk, "Prospects for Prepaid Group Practice," American Journal of Public Health, Vol. 59 (January, 1969.)

couraged to open their enrollment policies. As of 1973, eight of the twelve states which have enacted HMO legislation are requiring some form of enrollment beyond closed employee groups. These laws indicate that prepaid group practices must open their enrollments at least somewhat after a given length of developmental time--usually two years.

The "Health Maintenance Organization Act of 1973" sets the guidelines for a federally certified HMO. Section 301.4 of this act states that an HMO must "have an open enrollment period of not less than 30 days at least once during each consecutive twelfth month period during which enrollment period it accepts, up to its capacity, individuals in order in which they apply for enrollment, . . ."² It is becoming increasingly more clear that for HMOs to continue their popularity as a viable alternative to the existing health care delivery system, they must open their enrollments to serve the entire populus.

B - Purpose and Scope of this Study

This study is being undertaken to demonstrate the effects (or lack thereof) of an open enrollment on the utilization and costs of providing care in a prepaid group practice. For prepaid plans to fairly justify their claim as a low cost alternative health care

2. Health Maintenance Organization Act of 1973, (Washington Government Printing Office, Washington, D. C., 1973.)

delivery system, they must do so by servicing a cross section of the population.

C - Review of the Literature

A review of the literature describing group and nongroup experience in the HMO setting does more to demonstrate the need for further study in the area than shed much light on the topic. This is due largely to the fact that few, if any, other HMOs open their enrollments to a population at all comparable to the total population.

In contrast to their reluctance to provide services to the entire population, the proponents of many of these prepaid plans compare their rates of utilization of care to that of the general public or some other incomparable group of consumers.³ Such comparisons are invalid largely because of the selection process of those considered eligible for the plan. Some examples of

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3. Ray Bloomberg, "Group Practice Hospital: How Seattle Plan Works, How Doctors are Paid," Modern Hospital, Vol. 112 (May, 1969.)

Gunnar Fredriksen, "HMO's: New Horizons or Organizational Nightmares?" Hospital Progress, Vol. 53 (April, 1972), p. 44.

Gordon K. MacLeod and Jeffrey A. Prussin, "The Continuing Evolution of Health Maintenance Organizations," New England Journal of Medicine, Vol. 288 (March 1, 1973), p. 442.

Greer, Williams, "Kaiser: What is it? How Does it Work? Why Does it Work?" Modern Hospital, Vol. 116 (February 1971), p. 78 & 83.

eligibility requirements used to "weed out" alleged high risk groups include employment with an acceptable group, a pre-enrollment physical to screen pre-existing conditions, a large initial capital investment, or ownership of a home. "These medical care systems (HMOs) cater essentially to the working populations. The socioeconomic population distribution is truncated because the very poor and the wealthy are not included. Particularly if poor populations are excluded, HMOs are not likely to have the widespread significance in solving the problems in universal access to medical care."⁴

A study completed by Densen, Shapiro, and Einhorn confirmed that high utilizers of care tend to remain high and low utilizers of care tend to remain low. While no attempt is made in the study to correlate high utilization with socioeconomic characteristics, the work implies such a relationship. A drawback of the study is that no attempt is made to correlate utilization with cost of providing care.⁵

4. Ernest Saward and Merwyn R. Greenlick, "Health Policy and the HMO," Milbank Memorial Fund Quarterly, Vol. 50 (April, 1972), p. 169.
5. Paul M. Densen, Sam Shapiro, and Marilyn Einhorn, "Concerning High and Low Utilizers of Service in a Medical Care Plan, and the Persistence of Utilization Levels Over a Three Year Period," Milbank Memorial Fund Quarterly, Vol. 37 (July, 1957), p. 217.

Research by Greenlick, Freeborn, Colombo, Prussin, and Saward compares the utilization of medical care services by the general membership of a prepaid group plan to that of an OEO Comprehensive Neighborhood Health Center program. Findings from the study are, however, non-generalizable to the total public in that the selection criteria for the OEO population included families with specific known health problems requiring attention.⁶

A research report conducted by Dr. Robert L. Peterson comparing inpatient and outpatient utilization of like populations concluded that inpatient hospital admission rates are generally lower for prepaid group practice enrollees than for comparable holders of private insurance policies. While the results of this study are conclusive, the groups involved again do not represent a cross section of the population.⁷

While these and other studies describing how prepaid group practices affect the utilization rates of their enrollees are useful, they do not describe a situation where care is provided to a cross section of the population. "What is regarded as the crucial test

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6. Merwyn R. Greenlick, Donald K. Freeborn, Theodore J. Colombo, et al, "Comparing the Use of Medical Care Services by a Medically Indigent and a General Membership Population in a Comprehensive Prepaid Group Practice Program," Medical Care, Vol. 10 (May-June, 1972), p. 187.
 7. Robert L. Robertson, "Comparative Medical Care Use Under Prepaid Group Practice and Free Choice Plans: A Case Study," Inquiry, Vol. 9 (September, 1972), p. 70.

for the prepayment, capitation, group plan would be its record in serving these segments of the population usually excluded from medical plans restricted to the gainfully employed. There is a lively curiosity about how a prepaid plan would fare with a low income group. "8

Another important issue is the extent to which congressional action will force some form of community rating on HMOs. It seems far better for this issue to be resolved in the context of national health insurance legislation than in statutes pertaining to HMOs. If HMOs are forced to community rate all or large numbers of their enrollees, such a constraint can only be viewed as a severe hindrance to their development and expansion, particularly if open enrollment is required. 9

This study will compare the health care experience of group and nongroup enrollees in a community-rated prepaid group plan who are comparable to the fee-for-service population of the same area.

D - Definition of Terms

Listed below are definitions of certain terms which will be referred to throughout the text of this paper. These definitions are meant to lend continuity to this study and may or may not correspond with definitions found elsewhere.

8. "Prepaid, Capitation, Group-Practice Plans of Health Care Including Health-Maintenance Organizations," New York State Journal of Medicine, Vol. 71 (September, 1971), p. 2211.
9. Robert D. Eilers, "The Implications of HMO's for Private Insurers," Inquiry, Vol. 10 (March, 1973), p. 62-63.

Greater Marshfield Community Health Plan (GMCHP): GMCHP is a prepaid group practice health plan sponsored by the Marshfield Clinic, St. Joseph's Hospital, and Wisconsin Blue Cross-Surgical Care Blue Shield. The plan is described as an HMO offering a comprehensive range of benefits for a fixed monthly fee with emphasis on the elimination of barriers toward receiving maintenance type care.

Eligible Population: The population eligible for enrollment in GMCHP is any person or persons under age 65 who live and/or work in Marshfield or 30 defined contiguous townships surrounding the Marshfield area. (See appendix A for map of the Greater Marshfield Community Health Plan area.)

Group Member: A group member is an enrollee in GMCHP who enters the plan within a block of five or more contracts. This block is a group of persons associated for some purpose other than the sole ends of purchasing insurance.

Nongroup Member: A nongroup member is an enrollee in the Greater Marshfield Community Health Plan who contracts directly with the plan for either himself or his family.

Community-Rating: Community-rating is the setting of an insurance charge based on the experience of the entire eligible

population. All insurees are charged the same contract rate irrespective of their place of employment, past insurance experience, or present medical condition.

Experience-Rating: Experience-rating is the determination of an insurance charge which varies within the insured block according to some predetermined parameters. The GMCHP offers only a community rate in that all plan participants, whether group or nongroup, are charged the same contract rate.

Open Enrollment Period: An open enrollment period is a designated length of time during the year when any eligible person or persons may join the GMCHP. Nongroup enrollees must enroll during such periods while group contracts are accepted at any time. This is done to protect the plan from those who would enroll with the intent to satisfy some known, significant medical problem.

Encounter: An encounter is an ambulatory contact between the patient and the provider of health care. "Provider refers to a physician, oral surgeon or other person primarily responsible for assessing the condition of the patient, for exercising independent judgement as to the care of the patient, and for

services rendered for a given encounter."¹⁰ Physician assistants, nurse practitioners, speech therapists, and audiologists may be considered as providers of care.

Because the Marshfield Clinic does fill out encounter forms, encounters have been approximated from computer records of patient registrations. One patient seeing one provider on one day is tallied as one encounter. One patient seeing three providers on one day is tallied as having three encounters. Laboratory tests and X-ray procedures are assigned to the provider ordering the tests. If no face-to-face contact occurs between the patient and the provider ordering the tests, an encounter is tallied for the procedure because it represents the expenditure of a health care resource. If such contact should occur, the tests are included with the contact encounter and only one encounter is tallied. Encounters are tallied for ambulatory contacts where no charge is made.

Inpatient Days: Inpatient days are the number of days of service rendered on an inpatient basis counted from the day of admission to the day before discharge.

10. Guidelines for Producing Uniform Data for Health Care Plans, (DHEW Pub. No. HSM 73-3005, 1972), p. 34.

Cost of Providing Care: The cost of providing care is that amount of resources (expressed in dollars) expended by the GMCHP in providing its enrollees with contracted benefits during a given period. For purposes of this study, the cost of providing care is approximated according to the limitations defined in Chapter II.

E - Clinic Setting

The Marshfield Clinic was founded as a multispecialty group practice in 1916 by six physicians. From this group has developed the present organization of 120 physicians representing 26 specialty and subspecialty departments. In the year 1973, the Marshfield Clinic had 212,014 registrations.

On March 1, 1971, the Clinic, in conjunction with St. Joseph's Hospital and Wisconsin Blue Cross-Surgical Care Blue Shield, began serving patients under the Greater Marshfield Community Health Plan. Negotiations between the three parties sponsoring the plan had been underway approximately one year prior to the plan's opening. (See Appendix B for an organizational chart of the GMCHP.)

Two objectives of the plan were "to establish the cost of high quality medical care in this type of program in rural Wisconsin, and to make the same comprehensive care available to all citizens within the Greater Marshfield area." In line with

the first objective, plan benefits were made as comprehensive as practical. (See Appendix C for provisions of the Greater Marshfield Community Health Plan.) Meeting the second objective involved opening the plan's enrollment to individual community members as well as employee groups. Individual enrollees are treated exactly as group members of the plan. No one receives a pre-enrollment physical to screen for pre-existing conditions; no initial deposits are required; and all enrollees are charged the same monthly contract rate.

Enrollment in the GMCHP has grown from 9,848 participants in January of 1972 to over 17,500 two years later. This represents approximately 40 percent of the population eligible for the plan.

Because of the large referral nature of the Marshfield Clinic, the GMCHP represents less than 12 percent of the gross income of the Marshfield Clinic.

In the fall and winter of 1973, the GMCHP expanded its target area to include two contiguous counties, Clark and Taylor. Experience from these affiliated plans will not be included in this study due to their presently small enrollments.

If anticipated income would motivate a physician's regime of treatment, the fee-for-service patient may tend to be "over-treated" while the GMCHP patient would receive less

care. However, all providers of care at the Marshfield Clinic are salaried employees. Further, from the outset of the plan, Clinic physicians indicated a preference toward treating plan members in the same manner as fee-for-service patients. To facilitate this, physicians are given no information regarding any patient's method of payment. The Marshfield Clinic physicians do not know whether or not the patient they are treating is a member of the GMCHP. (An unpublished report completed by Joel Broida confirmed this.) The utilization rates and corresponding costs of providing care presented in this study compare group and nongroup experience ordered by a physician whose actions are not guided by knowledge of the patient's method of payment.

F - The Hypotheses

The Greater Marshfield Community Health Plan serves a population which has been shown to represent a true cross section of the total population of the same area. Most operating HMOs limit their enrollment to include only low risk employee groups. Since lawmakers are encouraging prepaid health plans to broaden their eligibility requirements, a comparison of the GMCHP's experience with providing care to group and nongroup enrollees may be helpful to plans broadening their eligibility requirements to include nongroup enrollees.

The primary hypothesis of this study is that the utilization

and cost of providing health care to nongroup enrollees of the GMCHP does not differ significantly from the experience of the group enrollees. This notion leads to several secondary hypotheses to be tested. Briefly stated, these are that the nongroup enrollees, compared to the group members, will incur: 1) the same rate of outpatient encounters; 2) the same number of inpatient days; 3) the same costs for outpatient services; 4) the same costs for inpatient care; and 5) the same costs for total health care services provided.

CHAPTER II

METHODOLOGY

A - Study Design

In order to describe the GMCHPs group and nongroup experience in detail, percentage frequency distributions of group and nongroup enrollees were generated. These distributions categorized enrollees by number of encounters, number of inpatient days, and dollar intervals describing cost of outpatient care, inpatient care, and total health care costs. This study will include data from all persons enrolled and active in the plan from July 1, 1972 through June 31, 1973.¹ A full year cycle is chosen to eliminate seasonal variations in the utilization of health care. The specific year chosen for this study represents a time period during which the capitation rate paid the Clinic and per diem rate paid the hospital remained the same. Enrollee subscription fees were also constant.

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1. To simplify data collection and display, the experience of persons entering or exiting the plan during the study year will not be included.

The use of encounters as a measure of outpatient utilization carries with it certain limitations which must be noted. The definition of encounter usually varies from one institution to another. Often it is described as a face-to-face contact between an enrollee and a physician. Using this definition, the degree to which various plans utilize paramedical personnel can become important. For purposes of this study, the definition of encounter is meant to reflect some measure of the number of ambulatory health care resources expended by an enrollee (see page 9 for GMCHPs definition of encounter.) In light of potential discrepancies between what various plans define as an encounter, care must be taken in comparing GMCHPs outpatient encounter rate to that of other plans. However, insofar as encounters are tallied in the same manner for group and nongroup enrollees within this study, the relationship between the group and nongroup experience should be of value.

The method of tallying enrollee inpatient days is a bit more straightforward and universal among prepaid plans. Comparison to the GMCHPs experience is, however, subject to the limitation of its broad eligibility requirements for enrollment.

Besides comparing the utilization rates of group and nongroup enrollees, the costs of providing care to these units will be described. Because of the aforementioned difficulties in-

involved in the comparison of encounter rates, the costs of providing these outpatient services will be compared for the two units. Subject to the limitations of the costing method used, this comparison should reveal in terms of dollars how many more or less health care resources must be applied to the nongroup members of the GMCHP.

A comparison of the costs of providing inpatient care to group and nongroup enrollees includes both the costs of hospitalization, and the cost of physician services related to hospitalization. The hospital costs of the plan are computed by multiplying the number of inpatient days experienced times the per diem rate paid the hospital (\$90.00 per person per day during the time of this study.) The cost of physician services related to inpatient hospitalization is an approximation of the resources expended by the Clinic subject to the limitations described in Section D of this chapter.

The last frequency distribution describing the total costs of providing prepaid health care to group and nongroup enrollees is a summation of the above two.

B - Study Approach

The initial portion of this study describes one year's experience of the GMCHP with its group and nongroup enrollees beginning July 1, 1972. Since the plan began offering its benefits

on March 1, 1971, the findings of this study would reflect the experience of a relatively new prepaid plan with its open enrollment.

A major fear of plans contemplating an open enrollment as is present in the GMCHP is the notion that nongroup enrollees may join to satisfy some large, known, unmet medical need. Assuming that this phenomenon does occur to some extent, it would seem logical to conclude that as these health care needs are satisfied, the phenomenon will occur to a lesser degree in each succeeding open enrollment period. The open enrollment period will work to deplete this pool of unmet health care needs.

This study depicts the GMCHPs experience with nongroup enrollees during the relative infancy of the prepaid plan. The degree to which the above described phenomenon will affect the findings of the initial portion of this study is unknown.

In attempt to adjust for the alleged occurrence of this phenomenon, a second study will be undertaken with a format identical to the initial work. This study will focus on only those group and nongroup members enrolled in the GMCHP at least six months prior to the beginning of the study (i. e. January 1, 1972.) By studying this experienced subpopulation of the total plan, it is expected that the pool of unmet health care needs will have been largely satisfied prior to the study year.

It is also anticipated that this portion of the study will more closely approximate the group and nongroup experience of a more maturely developed prepaid group practice than the GMCHP. This subgroup study will test the same hypotheses as the total plan study.

If it is true that there is an initial level of high utilization, as unmet needs are discharged, the experience of the group and nongroup enrollees should be more similar in the second portion of the study.

C - Limitations

The findings obtained from this study are limited in their universal applicability by certain characteristics which may or may not be unique to the Greater Marshfield Community Health Plan. The sampling involved in this study are all those enrollees of the GMCHP who were active from July 1, 1972 through June 30, 1973. Anyone under age 65 living or working in the defined thirty township area surrounding the city of Marshfield was eligible to join the plan. (See Appendix A for a map of GMCHP area.) Approximately 25 percent of the total enrollment of the plan consists of nongroup members who entered during an open enrollment period.

Approximately 40 percent of the under 65 area population is enrolled in the plan. A study was undertaken by Harry Sharp, PH. D.

for the Marshfield Clinic Foundation for Medical Research and Education to compare the socioeconomic characteristics of the population enrolled in the GMCHP to area residents under 65 not enrolled in the plan. His work indicated that the socioeconomic characteristics of the population enrolled in the plan are essentially the same as the fee-for-service population of the same area.²

The presence of the Marshfield Clinic employees and their families as well as certain other groups are factors which must be considered in the interpretation of the findings of this study.

Employees and their families of the Marshfield Clinic and St. Joseph's Hospital, Marshfield, Wisconsin, are both units described in this study as group enrollees. Their sophisticated knowledge of the health care system makes them less reluctant to utilize health care. Their presence in this study works to some degree to "inflate" the utilization and cost data of groups enrolled in GMCHP. As of July, 1973, Clinic and hospital enrollees in the plan numbered 1, 942 and 2, 318 respectively (approximately 28 percent of the total enrollment.)

2. Harry Sharp, "An Analysis of the Greater Marshfield Community Health Plan Terminations," Marshfield, Wisconsin (an unpublished report done for the Marshfield Clinic Foundation for Medical Research and Education, Inc., 1973), p. 78.

Another factor which may influence the results of this study is the variable percentage of GMCHP premium paid by the employer for his group units and any resulting psychological effect on utilization. Most employers of groups in the plan pay over 50 percent of their employees' premiums. A commonly held, though unproven, assumption holds that the more a person pays "out-of-pocket" towards his care, the more likely he is to use that care. Everyone wants to get their money's worth. A large unit included with the group data of this study are the dairy farm cooperative groups (2,612 participants in July of 1973.) These dairymen "group" themselves according to where they sell their products. Their association does not contribute towards the payment of GMCHP premiums. The degree to which this effects their utilization of plan benefits is not known, though it is suspected this group may behave more as a nongroup.

The presence of health care-related groups and dairy cooperative "nongroup groups" in the group data of this study may to some degree be offsetting. Further study would be needed to determine how each of these units affects the utilization and cost of providing care of group enrollees in GMCHP.

The method used to determine the cost of providing services to prepaid plan participants may also affect the findings of this study. The Marshfield Clinic does not determine its plan

costs according to each procedure performed or service provided. For purposes of this study, the costs of providing care to plan participants will be approximated as a percentage of what would be charged for the same procedures on a fee-for-service basis. This percentage was determined by subtracting the cost of credit and collections and cashiers departments, provision for discounts and allowances, and profits realized from Clinic operating expenses during the year. The costs associated with these areas are thought to represent resources not applied to Greater Marshfield Plan participants.

While discounting charges for an individual procedure in this manner would not necessarily reflect that procedures cost, subtracting these budgetary items from the Clinic's total yearly charges closely approximates total plan costs. The accuracy or validity of this method of cost finding is an issue beyond the scope and intent of this study.

D - Method of Data Collection

The data for this study were obtained from computerized files summarizing monthly charges posted to patient accounts. These files are maintained for billing purposes on all patients receiving care at the Marshfield Clinic irrespective of their method of payment. Because GMCHP patient accounts are tallied in the same manner as fee-for-service accounts, the data obtained from these files are considered to be accurate.

E - Statistical Testing

Most statistical studies involve the gathering of certain descriptive summaries from a randomly gathered sampling of a general population. Various statistical tests are performed on that data. If all the assumptions of the model are fulfilled and the sampling gathered is indeed random, certain inferences can be made from the sampling to the general population which hold true with a known probability. Because this study utilizes data describing all enrollees of the GMCHP during the given period, no inferences from any subset thereof are made to the general population. Conceptually then, this study describes the total GMCHP population as opposed to inferring generalizations from tests performed on a random sampling of that population.

The statistical tests which will be used to accept or reject the stated hypotheses will be chi-square, goodness of fit. Frequency distributions will be generated comparing group and nongroup plan experience according to the five categories described. Observed frequencies of occurrences in each grouping of a frequency distribution will be compared to expected values. Expected frequencies will be determined by multiplying the sum of group and nongroup experience in a class by the proportion of group and nongroup enrollees in the plan.

Because small hypothetical frequencies may distort the findings, where expected values fall below 5 for any class, classes of data will be grouped.³

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3. Jerome C. R. Li, Statistical Inference, (Edwards Brothers, Inc., Ann Arbor, Michigan, 1964), p. 494.

CHAPTER III

ANALYSIS OF THE DATA

The findings of the study relating to the five hypotheses to be tested on both the total enrollment of the GMCHP and the described subpopulation will be summarized together. Each section will include a statement of the hypothesis, the calculated test statistic, the corresponding degrees of freedom, a graph depicting the data gathered, and a table summarizing the experience of both the total GMCHP and the experienced subgroup.

A - Outpatient Encounters1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of encounter."

A frequency distribution was generated whereby group and nongroup enrollees in the GMCHP were categorized according to the number of encounters they experienced during the study period. The statistical test of choice to compare the experience of the group and nongroup enrollees is chi-square goodness of fit (χ^2).

Application of this test to the generated frequency distribution involved the determination of hypothetical expected frequencies for each category. For example, 1,606 group enrollees experienced one encounter during the study year compared to 451 nongroup members of the plan. Since a total of 2,057 plan members experienced one encounter, it can be expected that the number of these which were group and nongroup enrollees is proportional to the total group to nongroup enrollment during the study year. Since group enrollment represented 76.4 percent of the total enrollment of the plan, it could be expected that 76.4 percent of those enrollees experiencing one encounter, would be group members. The expected number of group enrollees experiencing one encounter is then 2,057 times .764 or 1,571.5 enrollees. The expected values of all classes of data in this study were computed in this manner. (See Appendix D for a sample of the chi-square goodness of fit computation.)

The one-sided statistical test was performed on the group and nongroup frequency distributions describing the number of encounters experienced during the study year by persons within the respective units. The test was performed at the significance level of .05. The resulting test statistic value of 42.25 was more than the critical value of 37.652 at 25 degrees of freedom.¹

1. Richard D. Remington and M. Anthony Schork, Statistics with Applications to the Biological Sciences, (Prentice-Hall), Table A-6, p. 376.

Based on the relative frequency of the total population of the GMCHPs encounter rate, one can expect two randomly gathered distributions to be more dissimilar than the two observed less than .025 of the time. The hypothesis is therefore rejected. During the study year, the relative frequency of encounter rates realized by group enrollees of the Greater Marshfield Community Health Plan was significantly different from the experience of the nongroup enrollees. (See Appendix E for a sample of the hypothesis testing method used.)

Graph I (see next page) shows a frequency distribution of group and nongroup enrollees by their encounter rates. The graph uses percent of the group and nongroup unit population as opposed to their raw numbers in order to overlay their experience. The comparison is drawn on semi-logarithmic paper in order to more clearly depict the experience on the tail of the frequency distribution.

Table I compares some summary statistics on the group and nongroup outpatient experience for the study year.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY FREQUENCY OF ENCOUNTER

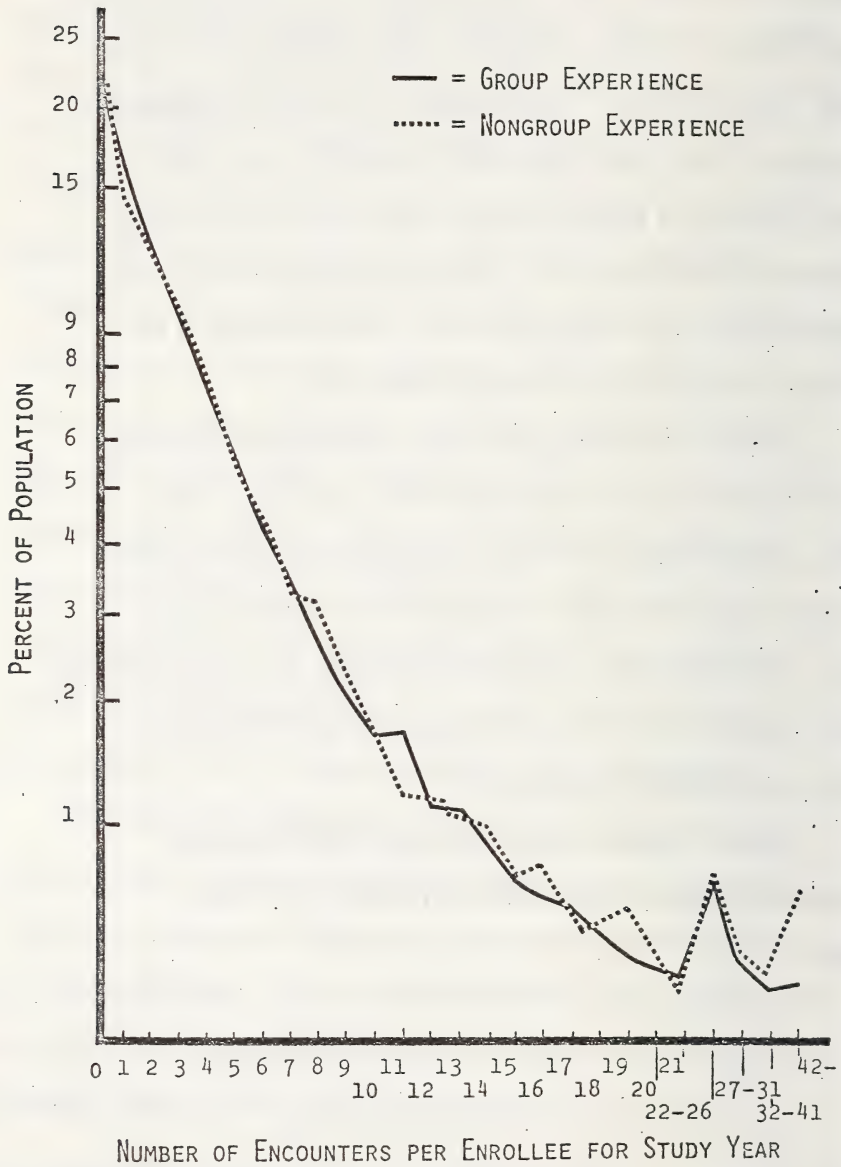


Table I

Comparison of Group and Nongroup Outpatient Encounters

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
No. of Encounters	38,603	75.0	12,871	25.0	51,474
(Subgroup)	32,073	76.6	9,822	23.4	41,895
Encounters/Enrollee	3.813		4.106		3.882
(Subgroup)	3.831		4.226		3.917

As can be seen from the table, while the nongroup enrollees represent 23.6 percent of the enrolled population, they account for 25.0 percent of all encounters. The nongroup subpopulation with at least six months experience prior to the study year, represent 21.7 percent of the total subpopulation while accounting for 23.4 percent of the total encounters.

The average number of encounters experienced per person during the study year was 3.882. The nongroup enrollees experienced an average of over .2 encounters per year more than this with a rate of 4.106. It is interesting to note that the nongroup subpopulation with more experience in the plan realized the highest mean encounter rate of 4.226 encounters per person per year. A comparison of the mean yearly encounter

rate of all group enrollees with the ambulatory utilization rate of the more experienced subgroup shows little difference.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees in the subpopulation have the same set of relative frequencies of encounter."

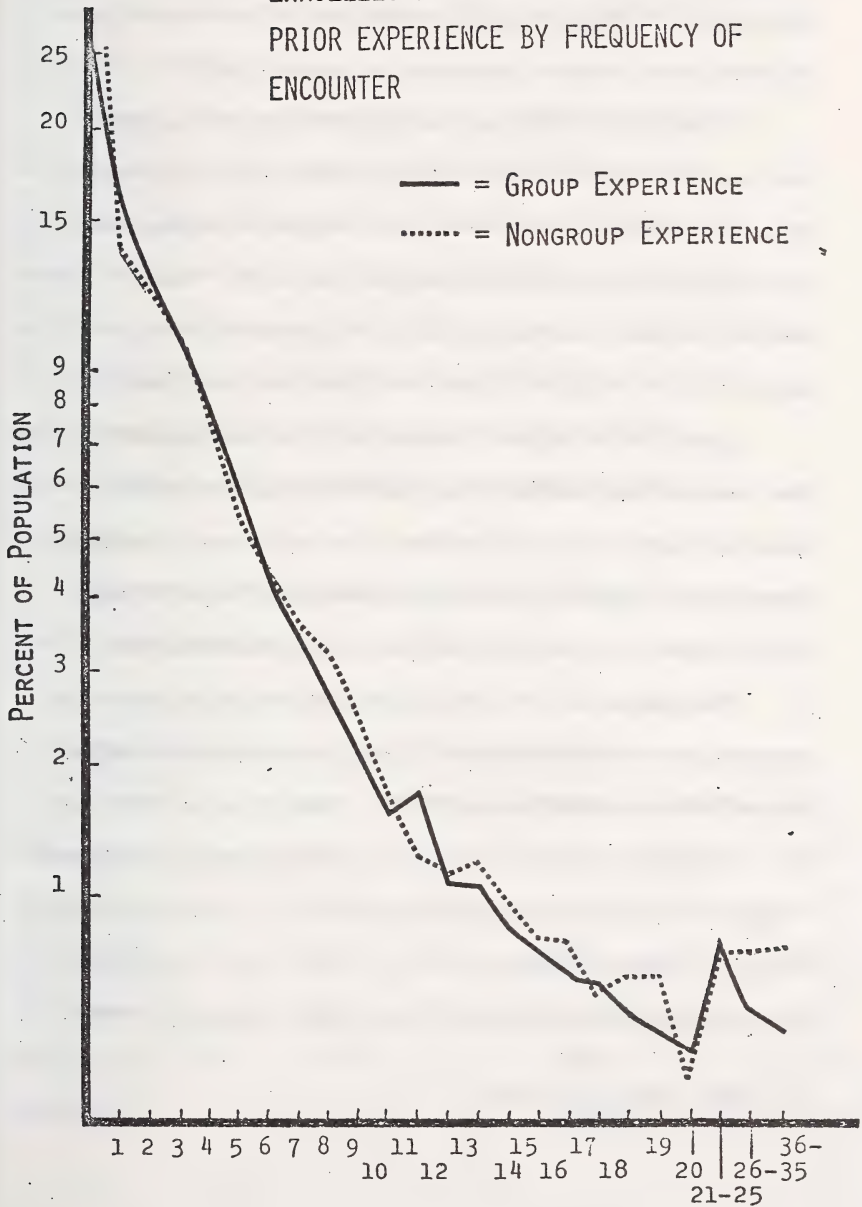
Application of the chi-square goodness of fit test to the frequency of encounters incurred by these group and nongroup subpopulations of the total study yielded a test statistic value of 30.95 at 22 degrees of freedom.² Since this is less than the defined critical value of 33.924,³ the hypothesis is accepted. That is, the encounter distribution is independent of type of enrollment.

Graph II (see next page) displays a percentage distribution of group and nongroup enrollees with experience in the plan by outpatient encounter. As in Graph I depicting ambulatory utilization for the total population, most of the variance between the group and nongroup utilization of ambulatory services occurs with persons experiencing ten or more ambulatory visits during the study year.

2. See Appendix F for a summary of this and all subsequent chi-square test results.

3. Remington and Schork, Table A-6, p. 376.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY FREQUENCY OF
ENCOUNTER



NUMBER OF ENCOUNTERS PER ENROLLEE FOR STUDY YEAR

B - Inpatient Utilization

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of inpatient days."

A frequency distribution was generated classifying group and nongroup enrollees experiencing hospital days during the study year according to how many days they were hospitalized. Tallying areas ranged from one hospital day to 49. Those hospitalized more than this amount were grouped as having experienced 50 or more hospital days during the study year.

Again, the chi-square goodness of fit test was applied to the frequency distribution. The hypothetical expected values were calculated in the same manner as in the encounter analysis. Hospital days experienced during the study year beyond 10 days were grouped to maintain the accuracy of the statistical test.

The application of the chi-square goodness of fit test to the inpatient utilization experienced by group and nongroup enrollees yielded a test statistic value of 27.34. Since grouping of the data was indicated by the small number of persons experiencing beyond 10 days, 12 degrees of freedom were allowed. The test statistic value was greater than the critical 21.026.⁴ Based on the total inpatient utilization experience of the GMCHP during the study

4. Ibid., Table A-6, p.376.

year, one can expect two randomly gathered samplings to be more dissimilar than the actual group and nongroup experience observed less than .01 of the time. The stated hypothesis is therefore rejected.

Graph III (see next page) displays a percentage distribution of group and nongroup hospital utilization for the total study population. The graph is made on semi-logarithmic paper to amplify experience at the tail of the distribution. As the graph indicates, a smaller percentage of the nongroup unit experienced less than six days hospitalization than of the group unit. However, beyond six days, the nongroup enrollees utilize proportionally more inpatient days than corresponding group members.

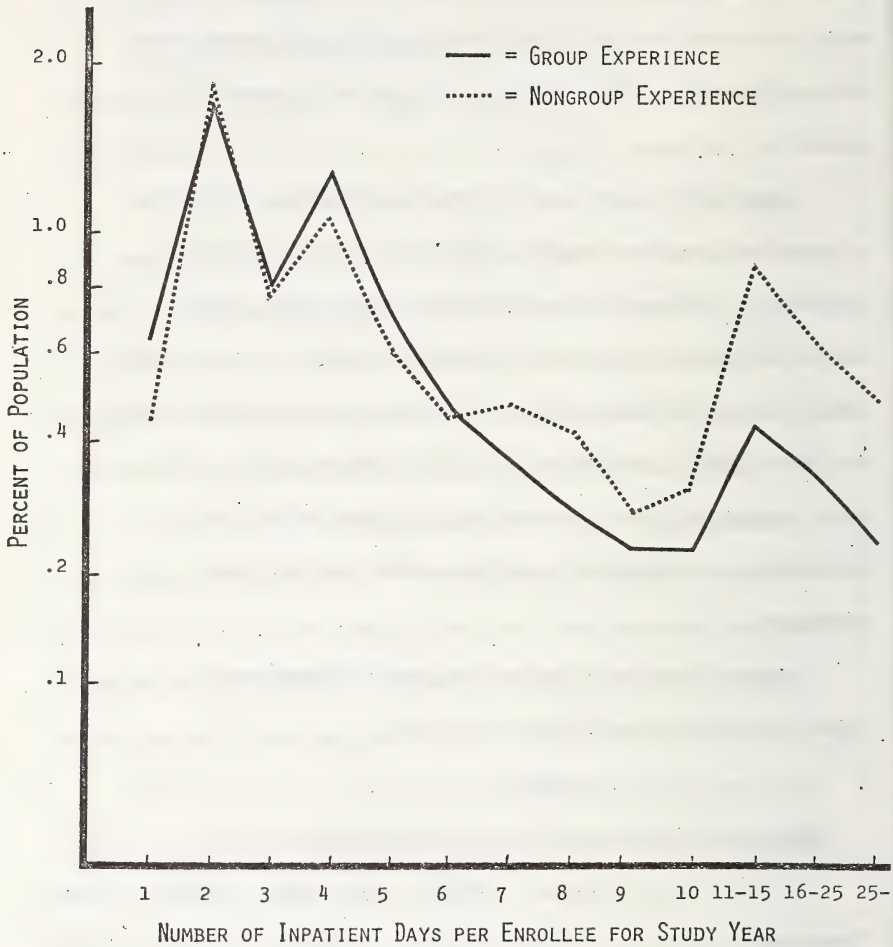
Summary statistics comparing group and nongroup inpatient utilization are found on Table II.

Table II

Comparison of Group and Nongroup Inpatient Days

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Hospital Days	5,044	66.9	2,494	33.1	7,538
(Subgroup)	4,206	69.9	1,815	30.1	6,021
Hospital Days/1000	498.2		795.5		568.5
(Subgroup)	502.3		780.9		562.8

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY FREQUENCY OF INPATIENT DAYS



In the total population study, nongroup enrollees represent 23.6 percent of the total GMCHP population while accounting for 33.1 percent of all inpatient days utilized. During the study year, the nongroup unit experienced 795.5 days of hospitalization per 1000 population--almost 300 more than group enrollees.

The subgroup study of enrollees with six month's prior experience yielded less dramatic differences. The 21.7 percent nongroup population accounted for 30.1 percent of the inpatient days experienced. Compared to the total population, the group enrolled subpopulation experienced 3.1 per 1000 population more inpatient days than the group enrollees of the total population. Conversely, nongroup enrollees with prior experience in the plan, utilized nearly 15 hospital days per 1000 less than the nongroup enrollees in the total population.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees have the same set of relative frequencies of inpatient days."

The frequency distribution of inpatient utilization was gathered and analyzed in the same manner as the data from the total population study. Application of the chi-square goodness of fit test yielded a test statistic value of 17.25. At 11 degrees of freedom, this is less than the critical value of 19.675.⁵

5. Ibid., Table A-6, p. 376.

The P-value associated with the test statistic is greater than .10 and the hypothesis is accepted. That is, the distribution of inpatient days is independent of type of enrollment.

Graph IV (see next page) compares the inpatient utilization of group and nongroup enrollees within this subpopulation. As in Graph III depicting the hospital utilization of the total plan, the proportion of the group and nongroup population experiencing less than six day's hospitalization per year is quite comparable. While the percentage of the nongroup enrollees experiencing more than six day's hospital care per year is higher than the group rate, the difference is not so great with this experienced group as was noted in the total population study.

C - Outpatient Costs

1. Total Population Study

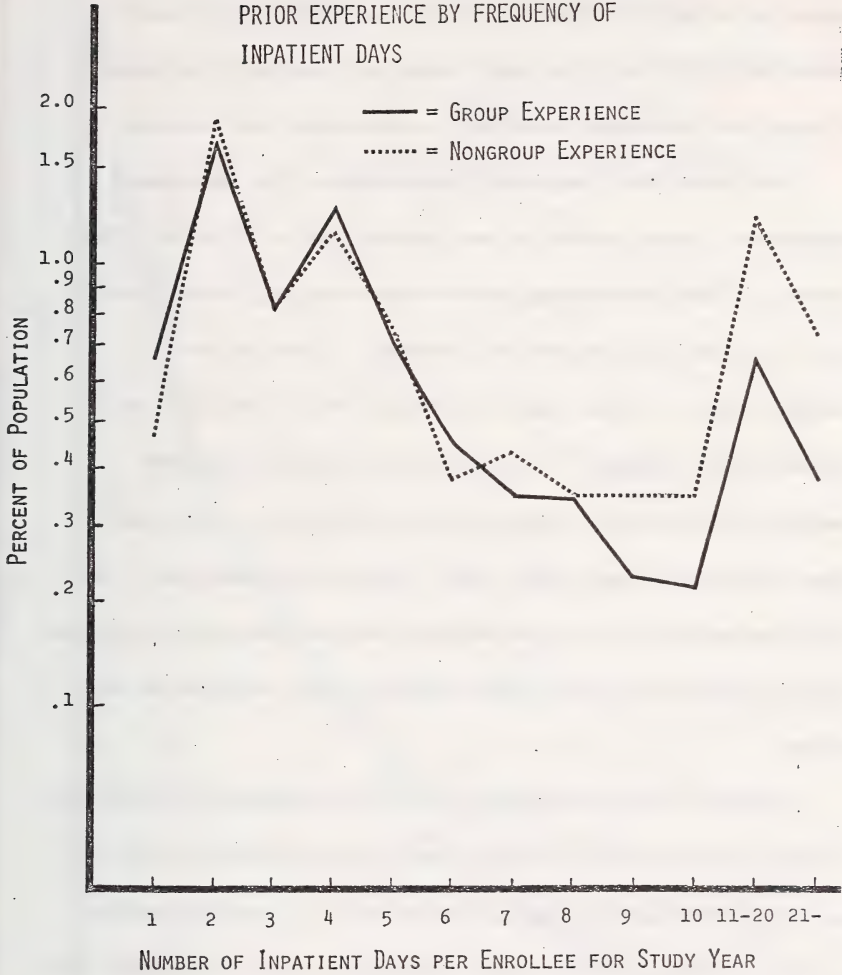
Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of outpatient costs."

Testing this hypothesis involved the generation of a frequency distribution categorizing group and nongroup enrollees according to the cost of ambulatory care they incurred during the study year. The costing method used to differentiate between cost and charges is subject to the limitations previously mentioned. Group and nongroup enrollees were tallied into any one of 50 cost categories. Each category represented one \$20.00 interval

GRAPH IV

37

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY FREQUENCY OF
INPATIENT DAYS



beginning with \$.01 to \$20.00, \$20.01 to \$40.00, etc. and ending with \$980.00. The final "catch-all" category included all enrollees incurring ambulatory costs above this amount.

Subjecting this frequency distribution to the chi-square goodness of fit test yielded a test statistic value of 68.05. The grouping of data describing persons incurring high ambulatory costs resulted in 23 degrees of freedom. Since the test statistic value is higher than the critical 35.127 ($p=.05$), the hypothesis is rejected.⁶ The possibility of generating two frequency distributions which are more dissimilar from their expected values is less than .0005. During the study year, the cost of ambulatory care incurred by group and nongroup enrollees of the GMCHP was significantly different from what can be expected.

Graph V (see next page) overlays the population percentage of group and nongroup enrollees incurring ambulatory costs at the midpoint of \$20.00 intervals described. A greater portion of group enrollees incur annual ambulatory costs of less than \$120 while proportionally more nongroup than group enrollees incur costs higher than this.

6. Ibid., Table A-6, p. 376.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY COST OF OUTPATIENT CARE.

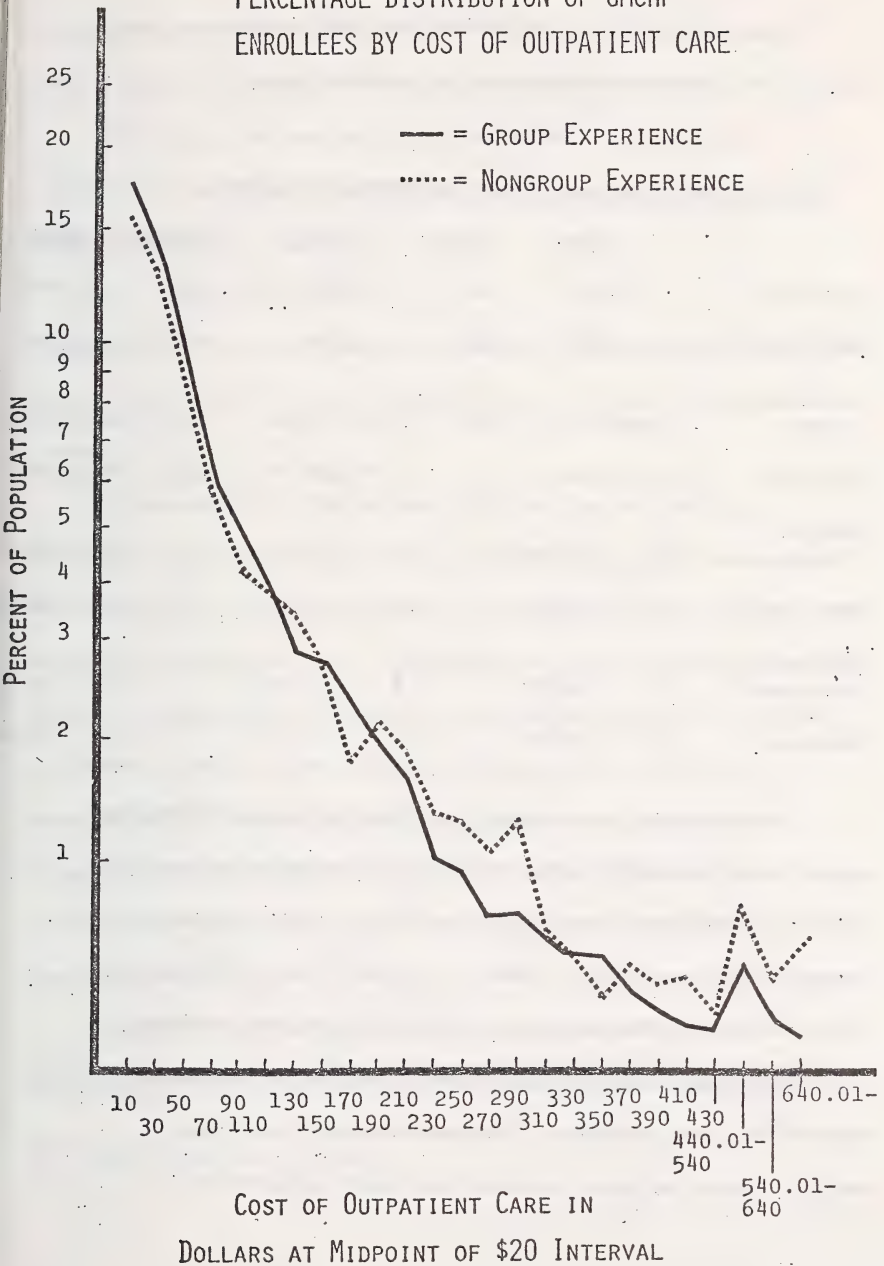


Table III summarizes the cost of providing ambulatory care to group and nongroup enrollees during the study year.

Table III

Comparison of Group and Nongroup Ambulatory Costs

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Ambulatory Costs	\$644,309.89	73.8	\$229,237.48	26.2	\$873,547.3
(Subgroup)	\$535,404.37	75.3	\$175,404.76	24.7	\$710,809.1
Cost per Enrollee	\$ 63.64		\$ 73.12		\$ 65.8
(Subgroup)	\$ 63.94		\$ 75.48		\$ 66.4
Cost per Encounter	\$ 16.69		\$ 17.81		\$ 16.9
(Subgroup)	\$ 16.69		\$ 17.86		\$ 16.9

While nongroup enrollees account for 23.6 percent of the total population of the GMCHP, they utilize 26.2 percent of the cost of providing ambulatory care to plan members. Table I showed that nongroup enrollees utilize .29 more encounters per year than do group enrollees. This table shows that each encounter utilized by nongroup enrollees is also \$1.12 more expensive than those incurred by group members. This combination of nongroup members incurring more frequent, and more expensive en-

counters than group enrollees results in their annual outpatient health care costs being \$9.48 higher per person per year.

Both group and nongroup enrollees in the subpopulation study incur higher annual ambulatory health care costs than the total population.

2. Subpopulation Study

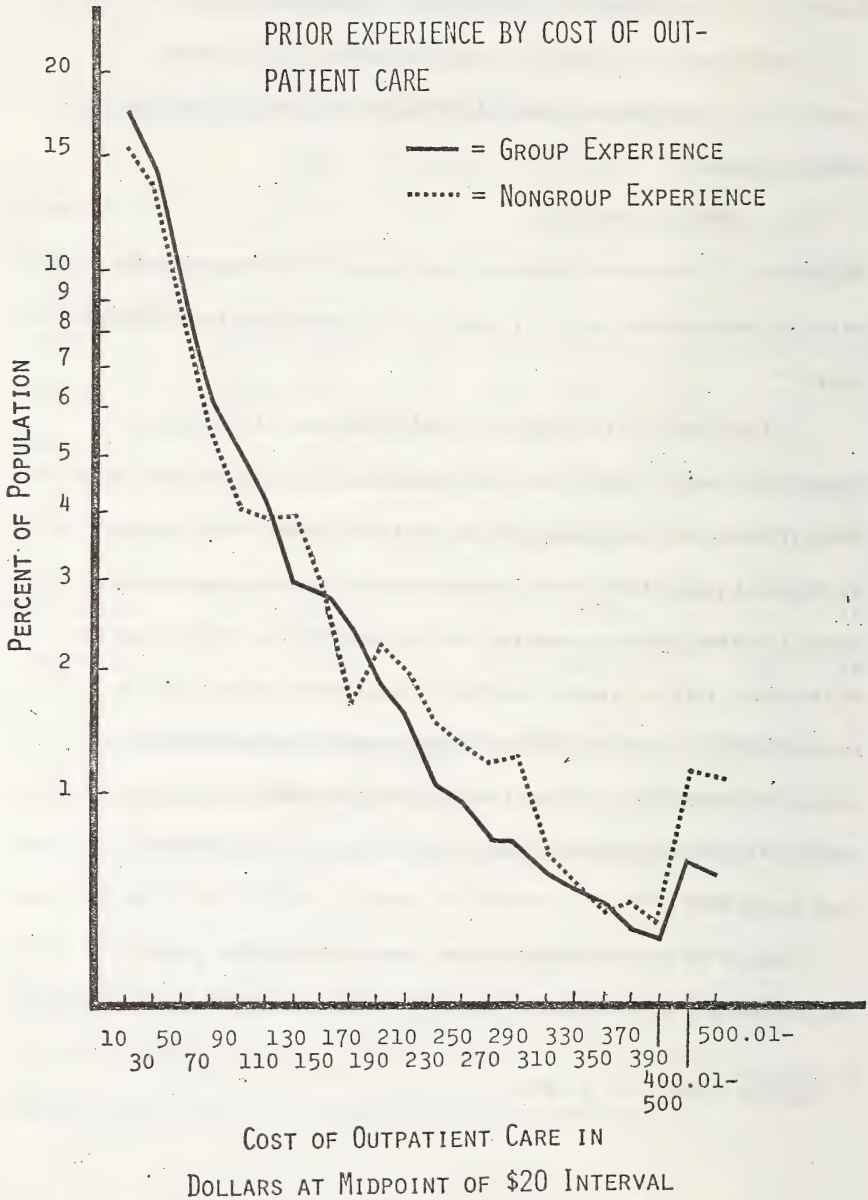
Hypothesis - "Group and nongroup enrollees in the subpopulation have the same set of relative frequencies of outpatient health care costs."

A frequency distribution describing the cost of providing ambulatory health care to this subpopulation of group and nongroup GMCHP enrollees was gathered and analyzed in the same manner as the total population study. Calculation of the chi-square goodness of fit test statistic resulted in a value of 62.65. At 21 degrees of freedom, this is greater than the critical value of 32.671 at a p-value of .05.⁷ The hypothesis is rejected. The probability associated with gathering two frequency distributions more dissimilar from the expected experience than the two observed is less than .0005.

Graph VI (see next page) shows the percent of the group and nongroup population falling into the various \$20.00 intervals

7. Ibid., Table A-6, p. 376.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY COST OF OUT-
PATIENT CARE



of ambulatory health care costs. Variances in the lines describing this subpopulation's ambulatory cost experience are less marked than Graph V depicting the experience of the total plan. The proportions of both group and nongroup enrollees with prior experience in the plan incurring high costs at the tail of the distribution are also higher than the experience of the total plan.

D - Inpatient Costs

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of inpatient costs."

The costs associated with hospitalization include both resources expended for the enrollee by the hospital and by the physician for his services. For purposes of this study, these costs have been approximated. Resources expended by the hospital on plan members are calculated by multiplying an enrollee's length of stay times the \$90.00 per diem rate paid to the hospital. While this does not reflect the true cost to the hospital of providing care to any one patient, it does represent the cost of hospitalization to the plan. The cost of providing physician services is approximated at a percentage of equivalent fee-for-service charges in the same manner as ambulatory costs.

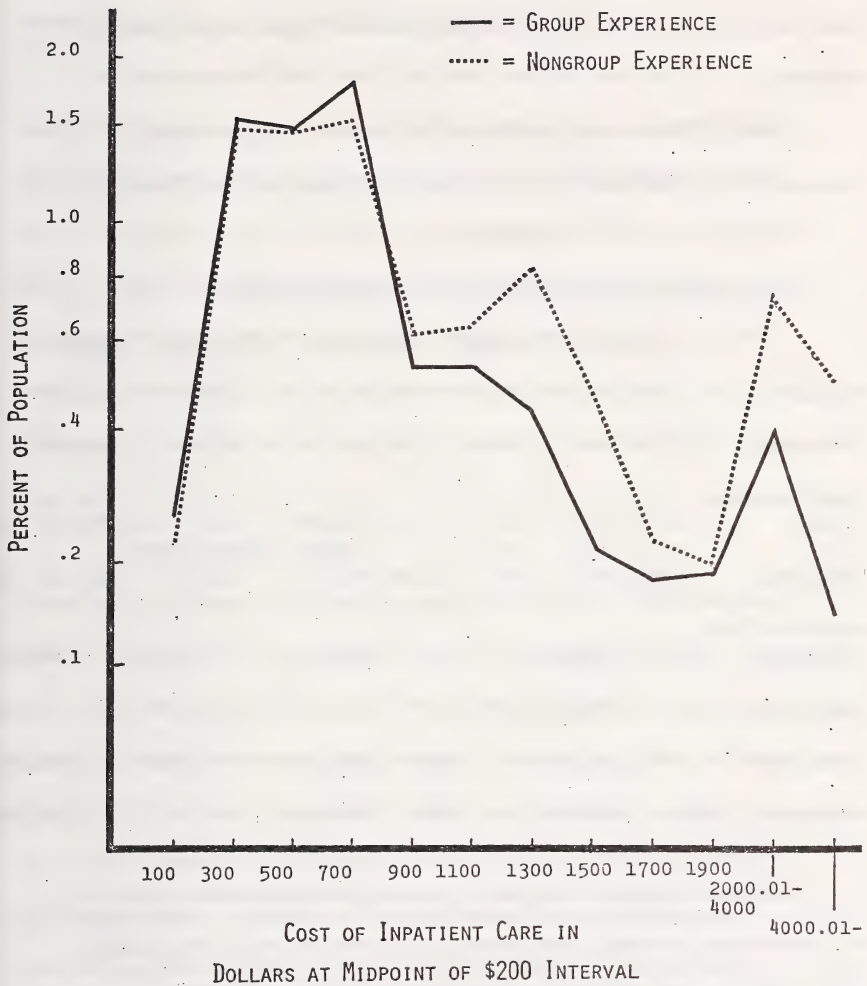
Subject to the above limitations, a frequency distribution was generated categorizing group and nongroup enrollees into 50 \$200.00 intervals describing cost of hospitalization. The last interval categorized patients incurring more than \$10,000.01 in hospitalization costs.

The application of the chi-square goodness of fit test involved the determination of hypothetical expected frequencies for each \$200.00 interval. These were calculated according to the same guidelines previously described. The calculated test statistic associated with the observed distribution was 30.59. Higher cost categories were grouped to achieve greater expected values. This resulted in 10 degrees of freedom. Since the calculated test statistic is higher than the critical 18.307 at 10 degrees of freedom ($p\text{-value} = .05$), the hypothesis is rejected.⁸ Two samplings randomly gathered from the expected frequency of group and nongroup inpatient costs can be expected to vary more than the observed experience less than .005 of the time.

Graph VII (see next page) shows the proportion of the group and nongroup enrollment experiencing inpatient costs at the mid-points of the described \$200.00 intervals. Experience at the tail of the distribution is grouped. The percent of the group and nongroup enrollment incurring hospital costs of less than \$800.00

8. Ibid., Table A-6, p. 376.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY COST OF INPATIENT CARE



during the study year is quite similar. However, proportionally more nongroup enrollees experienced inpatient costs beyond that amount.

Table IV lists some summary data on the inpatient costs incurred during the study year by group and nongroup enrollees.

Table IV

Comparison of Group and Nongroup Inpatient Costs

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	10,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Total Inpatient Costs	\$721,607.38	67.3	\$351,149.87	32.7	\$1,072,757.25
(Subgroup)	\$602,201.75	70.0	\$258,062.01	30.0	\$ 860,263.76
Inpatient Cost/ Enrollee	\$ 71.28		\$ 112.01		\$ 80.91
(Subgroup)	\$ 71.92		\$ 111.04		\$ 80.42
Cost/Day	\$ 143.06		\$ 140.80		\$ 142.31
(Subgroup)	\$ 143.18		\$ 142.18		\$ 142.88

The table indicates that while the nongroup enrollees represent 23.6 percent of the total plan, they incur 30.0 percent of the plan's costs associated with inpatient care. This compares with the nongroup's utilization of 33.1 percent of all inpatient days during the study year. The cost per day of inpatient hospitalization is

\$143.06 for group members of the total GMCHP while nongroup members incur average costs of \$140.80 per day.

In the subpopulation study, the cost per hospital day of nongroup members is \$1.38 higher than nongroup enrollees in the total population and more closely approximates the group experience. While the cost per hospital day is higher for these enrollees, their average yearly inpatient cost per enrollee is lower than nongroup members of the total population. The annual inpatient costs per enrollee in the subpopulation of group members with prior experience is higher than the comparable figure for the total plan.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees of the subpopulation have the same set of relative frequencies of inpatient costs."

The frequency distribution describing the hospital and physician costs associated with inpatient care of enrollees in the GMCHP with at least six months experience prior to the study year was gathered and analyzed in the same manner as the total population study. Applying this distribution to the chi-square goodness of fit test yielded a test statistic value of 19.76. At nine degrees of freedom, this exceeds the critical value of 16.919 at a p-value of .05.⁹ The hypothesis is rejected. The

9. Ibid., Table A-6, p. 376.

probability associated with gathering two samples from the expected distribution of this subpopulation's hospital costs which vary more than observations taken during the study year is less than .025.

The percent of group and nongroup enrollees with prior experience in the plan falling into the various \$200.00 intervals describing inpatient costs are depicted on Graph VIII (see next page.) The plotted group and nongroup experience with annual inpatient costs less than the \$900.00 interval for this subpopulation is quite similar to Graph VII depicting the total population. However, the frequency of enrollees of the two units falling into inpatient costs intervals beyond this amount more closely approximate each other in this subpopulation study.

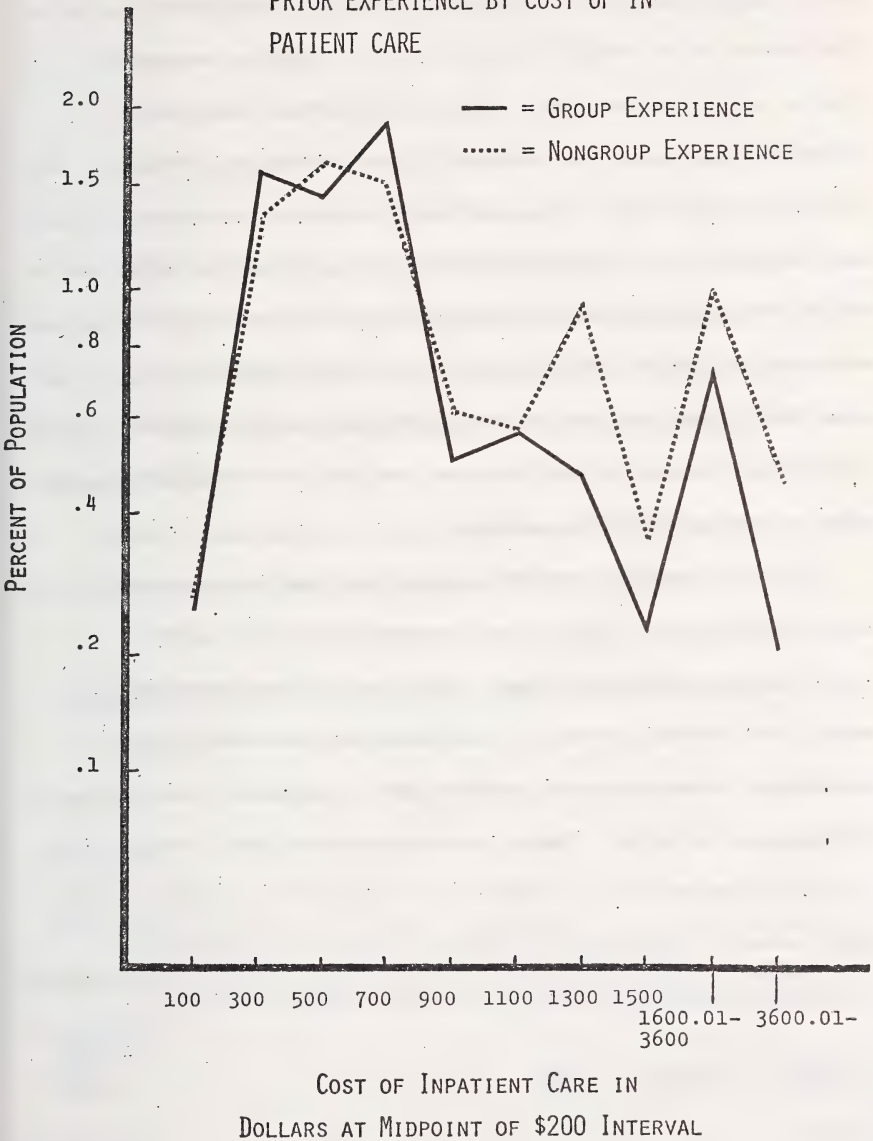
E - Total Health Care Costs

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of total health care costs."

The testing of this hypothesis involved the generation of a frequency distribution categorizing group and nongroup enrollees into intervals describing total inpatient and outpatient costs incurred by those enrollees during the study year. Not included in the data generated are the costs associated with the accounting administration of the plan and costs associated with out-of-area

PERCENTAGE DISTRIBUTION OF GMCHP
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PRIOR EXPERIENCE BY COST OF IN-
PATIENT CARE



emergency and referral service. Blue Cross and Surgical Care Blue Shield of Wisconsin are at risk for these plan components. This partner in the GMCHP charges \$1.00 per enrollee per month to cover accounting, administration, and marketing of the plan. During the study year, they received \$.41 per person per month to cover all out-of-area costs. Realized out-of-area costs for plan members were \$.31 during the study year. Since it is difficult to determine what portion of these amounts are associated with providing health care to group and nongroup enrollees and since Blue Cross receives the same amount per enrollee month, it is felt that omission of this from the cost data has a negligible effect on the findings of this section.

As in the inpatient cost study, group and nongroup enrollees were categorized into \$200.00 cost intervals describing health care costs incurred with the plan. The interval limits were the same as the hospital cost study. Subjecting the generated frequency distribution to the chi-square goodness of fit test yielded a test statistic value of 46.36. This is greater than the critical value of 19.675 ($p\text{-value}=.05$) at 11 degrees of freedom.¹⁰ Two randomly gathered samplings taken from the expected distribution of group and nongroup enrollees incurring health care costs

10. Ibid., Table A-6, p. 376.

during the study year can be expected to vary more than the observed distribution less than .0005 of the time. The hypothesis is therefore rejected.

Graph IX (see next page) depicts the percent of the group and nongroup population incurring annual health care costs at the midpoint of the described \$200.00 intervals. As can be seen on the graph, the group and nongroup experience does not vary markedly until health care costs exceed \$1,200.00 per person. The proportion of nongroup enrollees incurring costs beyond this amount is notably higher than a similar proportion of group enrollees.

Table V lists summary information regarding the total health care costs of group and nongroup GMCHP enrollees.

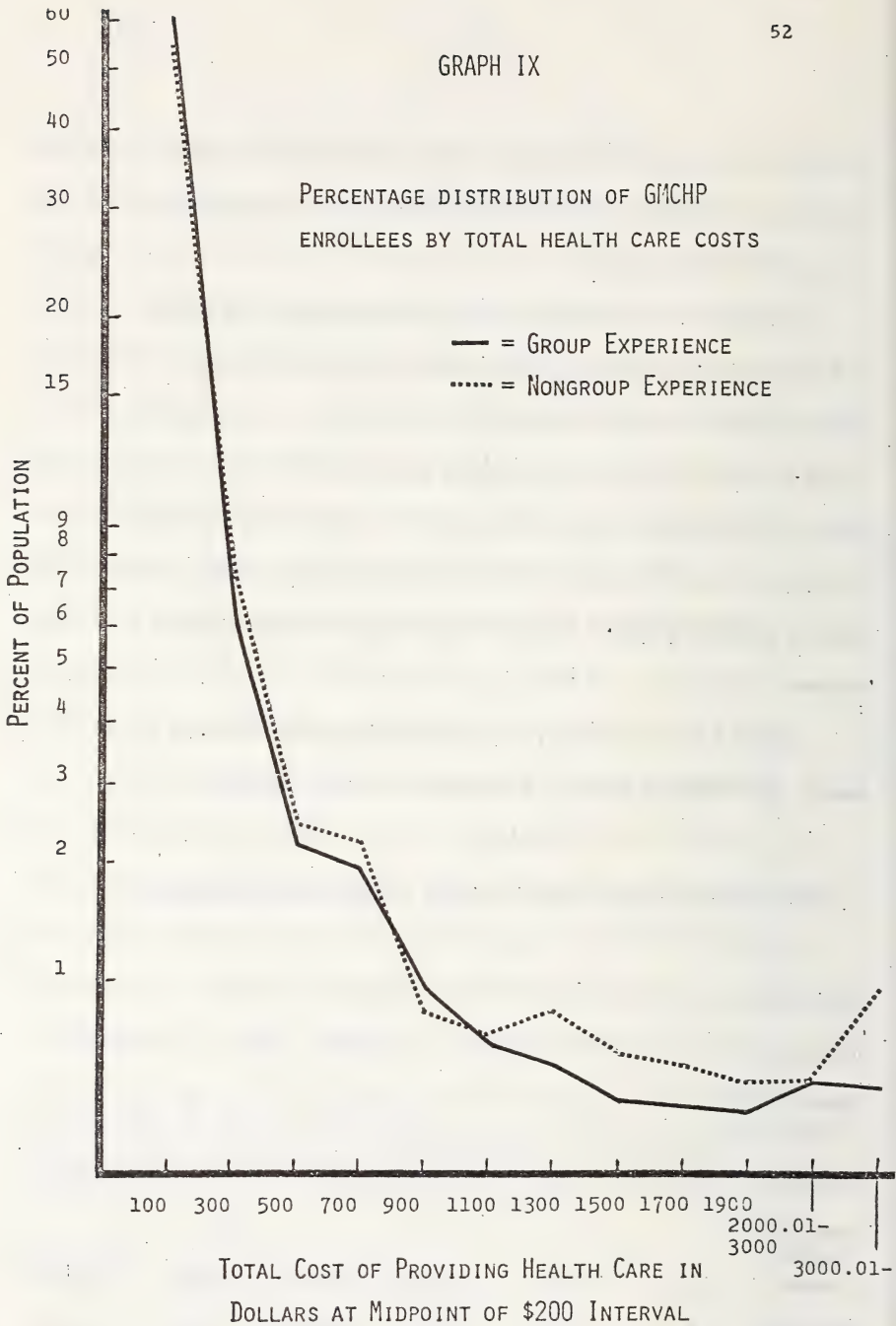
Table V

Comparison of Group and Nongroup Total Health Care Costs

Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Total Health Care Costs	\$1,366,058.44	70.1	\$581,522.74	29.9	\$1,947,581.18
(Subgroup)	\$1,137,667.01	72.4	\$434,458.08	27.6	\$1,572,125.09
Cost/En- rollee/ Month	\$ 11.24		\$ 15.46		\$ 12.24
(Subgroup)	\$ 11.32		\$ 15.58		\$ 12.25

GRAPH IX

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY TOTAL HEALTH CARE COSTS



As the table shows, nongroup enrollees in the total plan represent 23.6 percent of its population while accruing 29.9 percent of the inpatient and outpatient health care costs expended. The mean cost of providing health care to a nongroup enrollee per month is \$4.22 higher than for group enrollees. Because of the percentage mix of group to nongroup enrollees in the total GMCHP, group enrollees pay \$1.00 per month per person to underwrite the health care costs of the nongroup enrollees. Considering administrative and out-of-area costs (adding \$1.41 to group, nongroup, and total health care costs per enrollee per month,) nongroup enrollees utilize 25.0 percent more health care resources than do group enrollees.

Group and nongroup enrollees with at least six month's experience in the plan prior to the study year both incur monthly health care costs which are higher than the total population. However, due to their percentage mix of group to nongroup enrollees, this subgroup's mean monthly health care cost is only \$.01 higher than that of the total population.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees of the subpopulation have the same set of relative frequencies of total health care costs."

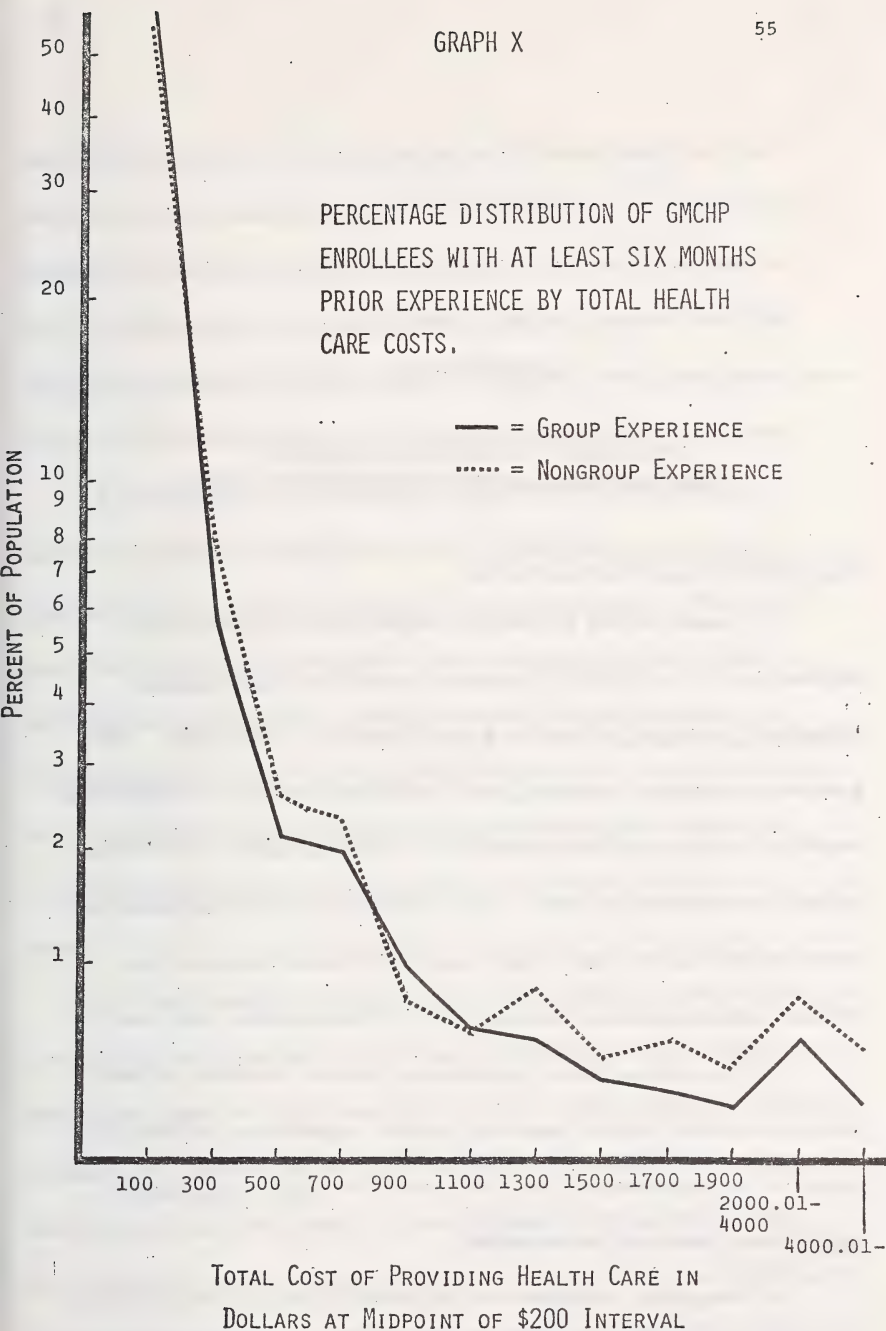
This frequency distribution categorizing group and non-group enrollees with experience in the plan according to their total health care costs was gathered and analyzed in the same manner as the total population study. Application of the chi-square goodness of fit test to the distribution generated yielded a test statistic value of 34.25. Allowing 10 degrees of freedom, this value is greater than the critical 18.307 at a p-value of .05.¹¹ The hypothesis is rejected. The probability associated with gathering two samplings from the hypothetical expected distribution more varied than the observed group and nongroup health care costs of this subpopulation is less than .0005.

A percentage of population distribution categorizing this subpopulation of group and nongroup enrollees at the midpoint of the \$200.00 interval describing their total health care costs for the study year is depicted with Graph X (see next page.) As in Graph IX, the percentage of nongroup enrollees experiencing health care costs beyond \$1,200 is notably higher than the group experience.

11. Ibid., Table A-6, p. 376.

GRAPH X

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CHAPTER IV

SUMMARY OF MAJOR FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

A - Summary of Major Findings

1. Based on the encounters experienced by the total population of the GMCHP, nongroup enrollees utilize more outpatient encounters than do group members of the plan. The greatest variances between group and nongroup use of outpatient services occur with those enrollees utilizing eight or more outpatient encounters per year. The average rate of encounter per enrollee during the study year was 3.882 while nongroup enrollees experienced an average of 4.106 encounters per year.

2. The utilization of ambulatory health services of nongroup enrollees with at least six months experience in the plan prior to the beginning of the study year does not vary significantly from what can be expected.

3. Nongroup enrollees utilize more inpatient hospital days than group enrollees. The greatest variances between group and

nongroup experience seems to occur with those enrollees experiencing more than nine days of hospitalization per year. A greater proportion of the group population utilizes less than six days hospitalization per year while a greater proportion of the nongroup population utilizes more. Nongroup enrollees experience nearly 300 hospital days per 1,000 more than group members.

4. Nongroup enrollees of the GMCHP with at least six months experience in the plan prior to the study year utilize inpatient care consistent with what can be expected. This nongroup unit, as a subpopulation of the nongroup unit described in the total population study, utilizes nearly 15 hospital days per 1,000 population less than the total nongroup unit. Comparably, the subpopulation group unit utilizes over four more days per 1,000 population than the group unit of the total population study.

5. The frequency of group and nongroup enrollees of the total GMCHP falling into \$20.00 intervals describing annual outpatient costs is significantly different. The average nongroup enrollee utilizes \$9.48 worth more ambulatory health care resources per year than does a group member. The mean cost per encounter of nongroup enrollees is \$17.81 compared to \$16.69 for group members. On the average, nongroup enrollees utilize more expensive encounters more often than do group enrollees.

6. As in the total population, nongroup enrollees in the subpopulation incur higher ambulatory health care costs than do group members with at least six months prior experience in the plan.

7. The cost of providing inpatient care to a nongroup enrollee in the GMCHP is higher than for a group member. However, the cost per hospital day is \$2.26 lower for these nongroup enrollees. On the average, group enrollees utilize less expensive inpatient care more frequently than group enrollees.

8. Nongroup enrollees of the subpopulation expend more resources for inpatient care than do group enrollees with prior experience in the plan. However, the plan spends fewer dollars per year for inpatient care on the average nongroup enrollee with prior experience than for those of the total plan. Nongroup enrollees with prior experience, while utilizing fewer hospital days than those of the total population, use more expensive inpatient care as measured by the cost per day of hospitalization. In contrast, the more experienced group enrollees utilize slightly more inpatient care than group members of the total plan.

9. Nongroup enrollees utilize 25.0 percent more health care resources measured in dollars than do group members. Considering the ratio of group to nongroup enrollees in the GMCHP, each single group enrollee pays \$1.00 per month to underwrite the health care costs of the nongroup members.

10. The total health care costs of both group and nongroup enrollees with six months prior experience is higher than respective units of the total health care plan. Group members of this subpopulation pay \$.93 per person per month to underwrite the health care costs of nongroup members of the subpopulation.

B - Conclusions

The above described findings lead the reader to several conclusions regarding health care utilization by nongroup members of the GMCHP as well as the validity of certain measures thereof.

1. Members of the GMCHP who enter the plan irrespective of their place of employment or pre-existing conditions during an open enrollment period utilize more health care resources than group enrollees in terms of both utilization of services and cost of providing those services.

2. The health care utilization behavior of nongroup enrollees with at least six months prior experience in the plan is different from that of all nongroup enrollees. These experienced nongroup members use more outpatient care and less inpatient care when compared to all nongroup enrollees. The health care behavior of group enrollees with experience is not affected in this manner.

3. The value of utilization statistics (i. e. outpatient encounters and inpatient days) when comparing even two units

within the same health plan may not reflect the true health care resources expended for that unit.

The importance of the small difference between the mean encounter rate of group and nongroup enrollees is magnified with the knowledge that the average nongroup encounter costs \$1.12 more. The difference between group and nongroup inpatient utilization is somewhat lessened by the fact that the average cost per nongroup incurred hospital day is \$2.26 less than for the group.

4. According to the frequency distributions generated, the bulk of the differences between group and nongroup utilization and cost of providing care occurs with a small percentage of nongroup enrollees who tend towards high utilization.

C - Recommendations

This study was undertaken to investigate the effects of an open enrollment on the utilization and costs of providing care in a prepaid group practice. Further, it was hoped that this study would demonstrate that these effects are not so dramatic as to prohibit an operational or developing prepaid group practice from including this segment of the health consumer population within its eligible population.

Utilizing the data files of the Marshfield Clinic, all enrollees of the GMCHP for a given year were categorized according

to group and nongroup status and displayed in frequency distributions describing outpatient and inpatient utilization, cost of outpatient care, cost of inpatient care, and total health care costs experienced. A second study similar in structure to the first was undertaken displaying only those group and nongroup enrollees with at least six months experience in the plan prior to the study year.

The study indicated that nongroup enrollees utilize 25 percent more health care resources measured in dollars than do group members. This difference is less in the group and nongroup subpopulation with at least six months prior experience in the plan.

Since legislators and consumers are encouraging HMOs to open their enrollments to the total population, it is hoped that this document will serve to describe one plan's experience with utilization, cost of providing care, and risk implications of such a policy.

In light of the findings of this study, the author recommends that the GMCHP continue its open enrollment and community rating policies. The degree to which group enrollees underwrite the health care costs of nongroup members is not prohibitive and tends to decrease with experience in the plan.

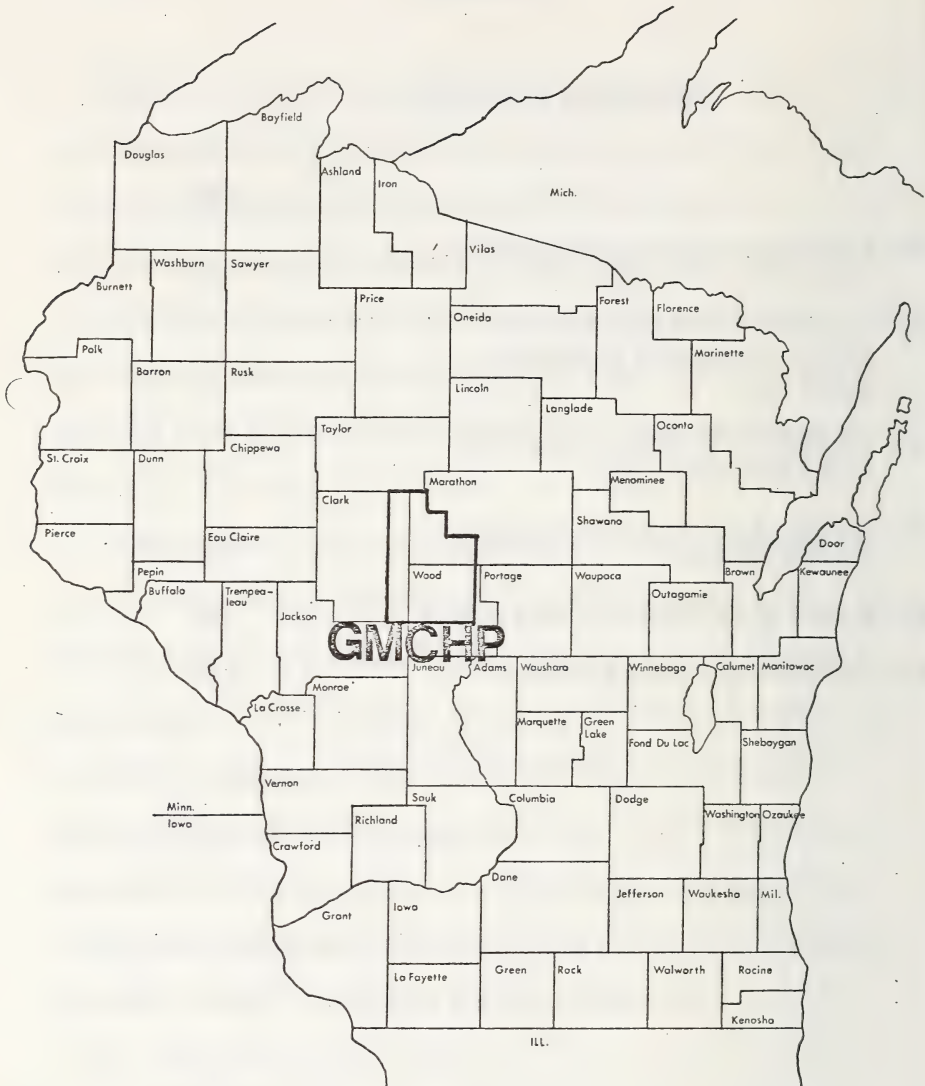
Certain characteristics unique to both the Greater Marshfield Community Health Plan and the community which it serves make generalization from the open enrollment experience described in this paper to other health plans difficult. However, insofar as current literature is void of any description of an HMO's experience with a community rated open enrollment, this pilot study may be taken as a base line for the experience of others.

If the Health Maintenance Organization is ever to conclusively demonstrate its viability as an alternative health care delivery system, it must do so by serving a true cross section of the population. The findings of this study demonstrate that providing all consumers--irrespective of employment or pre-existing conditions--with prepaid health care is not excessively prohibitive to the financial success of the plan. Therefore, the author would finally suggest that practicing and developing HMOs seriously consider establishing a policy of open enrollment.

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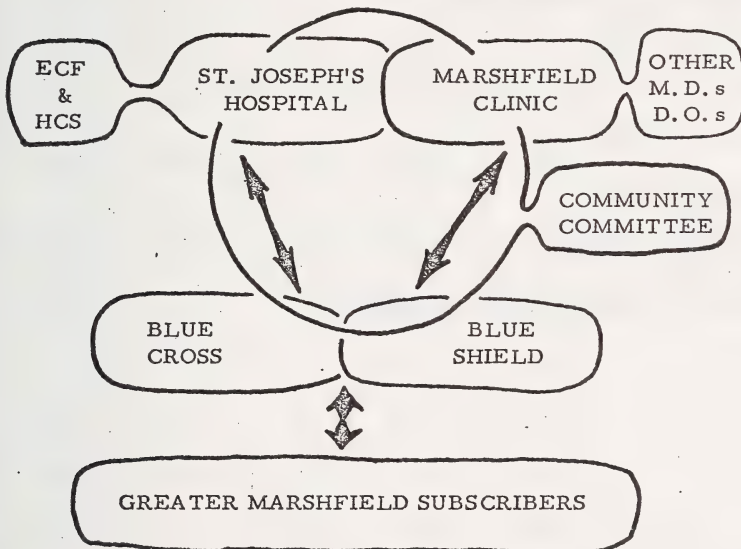
APPENDIX A



APPENDIX B

GREATER MARSHFIELD COMMUNITY HEALTH PLAN
COMPONENT LINKAGES

1. Marshfield Clinic: Provides medical services in and out of the hospital and makes separate contractual arrangements with affiliated physicians.
2. St. Joseph's Hospital: Provides inpatient services and makes arrangements for nursing home and home health care.
3. Blue Cross - Blue Shield: Perform marketing, enrollment, actuarial, claims and out of area services and administration.
4. Community Committee: Advice and guidance to the plan partners.



APPENDIX C

GMCHP BENEFITS

Complete coverage for:

Medical Care (Ambulatory and Inpatient)
Hospital, ECF, Home Care
Outpatient
Emergency Out of Area Service
Referral Care

Inpatient Care - 365 days (does not include psychiatric)

ECF 2 for 1 Home Care 5 for 1

Mental Health Care - Up to 70 days - inpatient
(70 more after 90)

Up to 10 mental health visits
(10 more after 90)

No physical exam required
No deductibles
No co-payments
No "pre-existing" exclusions (except maternity)

DOES NOT INCLUDE:

Outpatient drugs
Prosthetic devices
Cosmetic surgery
Eyeglasses
Dental care (other than oral surgery)

APPENDIX D

SAMPLE OF CHI-SQUARE COMPUTATION:

OUTPATIENT ENCOUNTERS--TOTAL POPULATION

Number of Encounters	People		Expected Frequency*		(O-E) ² /E	
	Group	Nongroup	Group	Nongroup	Group	Nongroup
0	2638	854	2667.9	824.1	.34	1.08
1	1606	451	1571.5	485.5	.76	2.45
2	1263	360	1240.0	383.0	.43	1.38
3	938	305	949.7	293.3	.14	.47
4	755	234	755.6	233.4	.00	.00
5	594	167	581.4	179.6	.27	.88
6	425	139	430.9	133.1	.08	.26
7	355	106	352.2	108.8	.02	.07
8	266	98	278.1	85.9	.53	1.70
9	211	76	219.3	67.7	.31	.99
10	170	54	171.9	52.1	.02	.07
11	180	36	165.0	51.0	1.36	4.41
12	111	36	112.3	34.7	.02	.05
13	114	33	112.3	34.7	.03	.08
14	85	30	87.9	27.1	.10	.31
15	66	21	66.5	20.5	.00	.01
16	55	24	60.4	19.6	.48	1.49

Number of Encounters	People		Expected Frequency*		(O-E) ² /E	
	Group	Nongroup	Group	Nongroup	Group	Nongroup
17	56	12	52.0	16.0	.31	1.00
18	37	15	39.7	12.3	.18	.59
19	29	16	34.4	10.6	.85	2.75
20	23	8	23.7	7.3	.02	.07
21	22	5	20.6	6.4	.10	.31
22-26	62	20	62.6	19.4	.01	.02
27-31	26	9	26.7	8.3	.02	.06
32-41	15	7	16.8	5.2	.19	.62
42-	19	19	29.0	9.0	3.45	11.11
Total Frequency	10,124	3,135			$\chi^2=42.25$	
Relative Frequency	.764	.236	.764	.236		

* Expected frequencies are obtained by multiplying the percent of population that is group and nongroup by the total number of observations within a class of encounters.

APPENDIX E

SAMPLE OF HYPOTHESIS TESTING:
OUTPATIENT ENCOUNTERS--TOTAL POPULATION

$$X^2 \leq \frac{(O-E)^2}{E} = 42.25$$

Degrees of freedom = (r-1) (c-1) = 25

Reject H_0 where $X^2 > 37.652$

At 25 degrees of freedom, the P-value of $X^2=42.25$ is .018. Since the level of significance for the P-value was set at .05 (i.e. if P-value is equal to or less than .05, reject the null hypothesis), the hypothesis is rejected.

APPENDIX F

SUMMARY OF CHI-SQUARE RESULTS

Factor	X^2	Degrees of Freedom*	P-value	Accept- Reject H_0 **
Outpatient Encounters	42.25	24	$< .025$	Reject
(Subpopulation)	30.95	22	$> .05$	Accept
Inpatient Days	27.34	12	$< .01$	Reject
(Subpopulation)	17.25	11	$> .10$	Accept
Outpatient Costs	68.05	23	$< .0005$	Reject
(Subpopulation)	62.65	21	$< .0005$	Reject
Hospital Costs	30.59	10	$< .005$	Reject
(Subpopulation)	19.76	9	$< .025$	Reject
Total Costs	46.36	11	$< .0005$	Reject
(Subpopulation)	34.25	10	$< .0005$	Reject

* Degrees of freedom vary due to grouping of data at the tails of a distribution.

** Hypothesis is rejected where P-value of X^2 or = to .05.

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Senator KENNEDY: This hearing is now adjourned.

[Whereupon, at 11:05 a.m., the subcommittee recessed, to reconvene at 9:34 a.m., Friday, December 12, 1975.]

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS, 1975

FRIDAY, DECEMBER 12, 1975

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:34 a.m., in room 4232, Dirksen Senate Office Building, Senator Richard S. Schweiker presiding pro tempore.

Present: Senators Kennedy, Nelson, Mondale, and Schweiker.

Committee staff present: Philip Caper, M.D., professional staff member, and Jay B. Cutler, minority counsel.

Senator SCHWEIKER (presiding pro tempore). The Senate Health Subcommittee will please come to order.

This morning we will receive further testimony on the Health Maintenance Organizations Amendments of 1975, S. 1926. Under the principal provisions of the bill:

1. The offering of supplemental health services would become optional by an HMO.

2. The requirement HMO's offer annual open enrollment for individual membership is eliminated.

3. Prepayment fixed under a community rating system would not be required for a period of 5 years after an HMO has become qualified under the statute.

4. The requirement that medical groups must have as their principal professional activity the provision of health services to members of HMOs is eliminated.

We have heard the testimony of the General Accounting Office and the Department of Health, Education, and Welfare. The GAO, in its testimony, stated they surveyed 308 HMO's, questioning them on the issues raised by the bill. On the bill's principal issues—basic and supplemental health services, open enrollment, and community rating—a majority responded these changes would be an improvement, making HMO's more competitive.

The Assistant Secretary for Health, Department of Health, Education, and Welfare, testified in support of the amendments. He stated HMO's should be allowed to compete on an equal footing without Federal subsidy. "HMO's simply cannot be expected to be the vehicle for solving the basic benefit package and coverage problems—particularly for high risk groups—of our society."

The testimony we receive this morning will show why these amendments are necessary for potential Health Maintenance Organizations

to market their services to the public—a step toward making the delivery of adequate health care to all Americans a reality.

The chairman of the subcommittee, Senator Kennedy, is detained on the floor of the Senate with an amendment. He asked for us to proceed and we'll receive his opening statement for the record at this point.

[The opening statement of Senator Kennedy follows:]

OPENING STATEMENT OF SENATOR EDWARD M. KENNEDY

I am pleased to open this second day of hearings into the proposed amendments to Public Law 93-222, the Health Maintenance Organization Act of 1973. Today we will hear from three witnesses, including a coalition of health care providers and insurers.

One of the proposed amendments supported by the coalition would delete what is in my view one of the most significant requirements of the Act—the open enrollment provision.

That provision requires a Federally certified HMO to enroll any individual able to pay the premium without regard to preexisting illness or state of health.

Because such a requirement placed solely on HMO's could result in the attraction of an unfairly high number of very sick enrollees, forcing the HMO to price itself out of the market, the conferees—in 1973—wisely provided the Secretary of the Department of Health, Education and Welfare with authority to waive that requirement under certain circumstances.

If continuation of an open enrollment policy threatens the financial viability of an HMO, results in a demographically nonrepresentative enrollment, or results in an enrollment in excess of the HMO's capacity, the requirement may be waived.

This provision was included as a result of the conferees recognition that an open enrollment policy could be difficult or impossible for some HMO's—particularly small and newly developing HMO's—to maintain. To my knowledge, no requests for waivers have been received or granted by the Department of Health, Education, and Welfare.

The supporters of the proposed amendments maintain that the open enrollment requirements—applied solely to HMO's and not competing health insurers would result in the enrollment of substantial numbers of patients requiring extensive care. Such a situation would, they fear, make it impossible for HMO's to “compete in the marketplace” because it would be necessary for them to charge high premiums to provide that care.

There is little doubt in my mind that maintenance of an open enrollment policy by an HMO will result in *some* adverse selection. The question is how much, and what affect will it have on the HMO's ability to enroll new subscribers?

To my knowledge, that question has been fairly tested in only one HMO in the country—the Marshfield Clinic in Wisconsin. We will have an opportunity to hear of their experience in detail later this morning.

I believe an issue of great importance is at stake here. Is it appropriate for the Federal government to acquiesce, by action or inaction,

to the antisocial practices of the health insurance industry? Is it not appropriate for the Federal government to use its considerable financial and statutory leverage to set new higher standards for the badly troubled health care industry? Are the concerns being expressed about the open enrollment requirement quantitatively and qualitatively valid, or are they borne of timidity, excessive conservatism, and unwillingness to innovate?

Is the objective HMO's which serve as a true community-wide resource—worth the possible price in somewhat slower development of large numbers of HMO's?

We all recognize the necessity to restructure the existing health care system. I believe it is also necessary to reorient its goals.

I hope the answers to these questions emerge from this series of hearings. I have no intention of allowing the important social issues raised by the act or the proposed amendments to be swept under the carpet.

Senator SCHWEIKER. In deference to Senator Kennedy, we would like to reverse the order of the witnesses so that he may be able to hear the consensus group, and I certainly want to comply with that request.

So we will begin by hearing from the Chamber of Commerce this morning.

I would like to call on Edward Field and David McIntire.

Senator Mondale, a member of the committee, will introduce Mr. McIntire and other members of the panel.

Senator Mondale.

Senator MONDALE. Thank you, Mr. Chairman. I appreciate this opportunity to introduce Mr. David McIntire, who is the manager of the employee benefits, General Mills, Inc.

General Mills, of course, is one of our great home-based Minnesota companies.

He is, among other things, a member of the Special Committee on the Nation's Health Care Needs of the U.S. Chamber of Commerce.

I am very, very pleased to have this chance to introduce him.

Mr. Chairman, later in the hearings, you will hear from another Minnesotan, and I might say wherever you find leadership and genius, there is usually a Minnesotan around.

I am also delighted to introduce Walter McClure of InterStudy. Dr. McClure has made a major study in the InterStudy group, which has been a consultant to HEW, various congressional committees, and helped by participating in the development of HMO and other health legislation. InterStudy is a nonpartisan, nonprofit foundation. He will appear later.

Thank you very much, Mr. Chairman, for permitting me to introduce these two fine Minnesotans.

Senator SCHWEIKER. I thank you very much, Senator Mondale. We are going out of order, I realize, and we caught you a little bit by surprise, but we appreciate it.

I want to say that Senator Mondale is a sponsor of this bill which we are holding hearings on this morning, S. 1926, so we greatly appreciate his leadership in the area.

Mr. Field, if you would proceed.

STATEMENT OF EDWARD L. FIELD, OPERATING VICE PRESIDENT OF EMPLOYEE RELATIONS FOR FEDERATED DEPARTMENT STORES, INC., CINCINNATI, OHIO; ACCOMPANIED BY DAVID F. MCINTYRE, MANAGER OF EMPLOYEE BENEFITS, GENERAL MILLS, INC., MINNEAPOLIS, MINN., AND ROSE P. WOODEN, COMMITTEE EXECUTIVE OF U.S. CHAMBER OF COMMERCE, SPECIAL COMMITTEE ON THE NATION'S HEALTH CARE NEEDS, A PANEL

Mr. FIELD. My name is Edward L. Field. I am operating vice president of employee relations for Federated Department Stores, Inc., headquartered in Cincinnati, Ohio.

I was a member of the chamber's Special Committee on the Nation's Health Care Needs for several years, and chaired its Subcommittee on Health Delivery System.

My associate today is David F. McIntire, manager of employee benefits, General Mills, Inc., headquartered in Minneapolis, Minn., and a member of the chamber's health committee.

Accompanying us is Rose P. Wooden, committee executive of the chamber's Special Committee on the Nation's Health Care Needs.

The U.S. Chamber welcomes this opportunity to support S. 1926, the Health Maintenance Organization Amendments of 1975. This issue is of vital concern to our membership which embraces more than 48,000 business enterprises, 3,600 trade and professional associations, and local and State chambers of commerce. The underlying membership is more than 5 million individuals and firms.

The chamber supported the original HMO Act which encompassed the concept of pilot-testing. We recognized the need to experiment with alternative methods of health care delivery. The business community keenly hopes that the HMO system will prove to be a means to effectuate reasonable constraints on the spiraling cost of health care.

Our concern is that HMO's have not developed as rapidly as we expected when the act was signed into law 2 years ago. We have found that certain provisions of the act are administratively impractical, from the point of view of both an employer and an HMO provider.

Other provisions tend to make HMO's not competitive with existing health care programs. Instead of encouraging the growth of HMO's the richness of the statutory benefit packages and certain of the organizational and operating procedures are acting as real deterrents.

We believe that S. 1926 was introduced to alleviate these problems. We commend this committee for considering proposed amendments, many of which we find to be constructive.

The chamber's specific comments on eight substantive amendments contained in S. 1926 follow in the order of their importance to business:

Section 10: The most serious problem for employers raised by the original act was the provision that a qualified HMO must be recognized by the employer for the dual choice option, even if only one employee resides in that HMO's service area.

This provision places an extremely heavy administrative burden on employers. Applying the 25-employee requirement in section 1310 to the HMO service area would relieve this problem.

The chamber support deletion of criminal penalties for employers who fail to offer the HMO option. We favor the substitution of civil

penalties assessed by the Secretary of Health, Education, and Welfare.

Section 5: We support reduction in the required benefit package to be offered by HMO's. Business is concerned that the HMO option be cost-competitive with the current company health benefit plans.

Further, it has been difficult for employers to determine the cost of individual HMO services beyond those offered by the company plan. Reducing the required benefit package to levels comparable to existing employee benefit plans will enable employers to determine their cost contribution to the HMO plan more easily. Adoption of the HMO concept will be increased by such a reduction in the level of required benefits. Otherwise, HMO's are put in a position of pricing themselves out of the market.

Senator SCHWEIKER. We are going to have to recess to go over for a vote in the Senate Chamber.

[Short recess.]

Senator NELSON [presiding pro tempore]. We will resume with the testimony of the Chamber of Commerce, Mr. Field.

Mr. FIELD. I am starting at the top of page 3, first full paragraph.

Section 2: The chamber supports making supplementary benefit schedules optional for HMO's, if health manpower is available and if the market can bear the additional costs. This provision would make the operation of HMO's more realistic.

Section 6: Regarding community rating, we believe HMO's should be able to market their product competitively with indemnity or Blue Cross/Blue Shield plans.

Normally, many indemnity and Blue Cross/Blue Shield plans are experience rated. We believe the amendment which would delay community rating should be strengthened to allow HMO's to experience rate in keeping with the traditional marketing procedure of major insurers and Blue Cross/Blue Shield plans.

Section 4: We generally support deletion of the requirement for an annual open enrollment. It is recognized that the intent of the act is to remove barriers to enrolling in the alternative HMO plans. However, to allow fledgling HMO's to get started, they should be allowed to compete on an equal basis with health insurance plans. The mechanism of placing open enrollment unilaterally on HMO's is prejudicial because it exposes HMO's to a greater proportion of high medical risk candidates.

The chamber is sympathetic to making relief available for persons with high medical risks, but opposes placing an excessive burden on one small share of the health industry. Congress should look to an equitable solution whereby both insurers and HMO's would share this risk of open enrollment.

Section 3: The chamber generally supports allowing individual practice association, IPA's, to continue their customary practice of providing HMO services directly to enrollees through arrangements with physicians and health care providers.

Senator NELSON. May I ask a question?

Under section 4 of your remarks, you say that you generally support the deletion of the requirement for an annual open enrollment. Then you go on to say:

It is recognized that the intent of the Act is to remove barriers to enrolling in the alternative HMO plan. However, to allow fledgling HMOs to get started, they should be allowed to compete on an equal basis with health insurance plans.

Are you suggesting, then, that perhaps for the beginning period of 2 or 3 years, that the new HMO need not have an open enrollment, but that thereafter it shall?

Mr. FIELD. I think, Senator, our concern is to start up the HMO's around the country. To get them going in viable organizations, they need to be able to compete competitively.

In the future, the opportunity of open enrollment may develop for some of them, but for them to begin with that at the present time is a real handicap.

Senator NELSON. As to changing the statute, and then, 2 years to 4 years later, trying to change it back: I have been around politics long enough to know what the vested interest groups position would be on that. They would be in here saying, "Well, we came under this law under false pretenses; we thought we could use experience ratings, and did not have to have open enrollment. And now the Congress is changing the law, changing the rules of the game."

I would consider it disastrous for the delivery of medical care if we were to eliminate the requirement for open enrollment.

It may be possible to not require open enrollment the first 2 or 3 years, but the issue is how we are going to take care of sick people. You know, I would love to start an insurance company in which all of our insureds are healthy people. I would be very rich. That is what a lot of people want to do, insurance companies as well as doctors. It is not what we are trying to accomplish in this country. We want sick people taken care of.

If you do not have open enrollment requirements, everybody is going to select off the top. Then where is that competition? The sick people are not going to get taken care of. Unless you are talking about a limited period in which a new HMO might be exempt for a year or two, or something, I would consider it a very damaging amendment to eliminate the present law's open enrollment requirement, in terms of accomplishing what I hope this country intends to accomplish, that is: Deliver medical care to sick people.

Mr. FIELD. Certainly, our prime concern is that at the present time, as we see it, the open enrollment is a handicap to getting the HMO's operative. That is our big concern at the present time.

Senator NELSON. Well, maybe they ought to look at the experience of a very large HMO that has open enrollment, and the testimony that will be made today on that, and that is the Marshfield Clinic Greater Marshfield Community Health Plan. It has had open enrollment for 5 years and it is large. It has 140 doctors. It is one of the largest clinics in this country. They have open enrollment experience, so it seems to me we ought to be looking at what a successful open enrollment HMO has been doing rather than having people say we are scared of open enrollment and, therefore, we should remove a very important, in fact, vital provision, it seems to me, in the law.

Anyway, to get back to my question, would you support some kind of modification that applied only to new HMO's?

Mr. FIELD. Well, Senator, I think our thrust at the moment is in terms of where we are at the present time in launching this whole HMO concept which we vigorously support.

Senator NELSON. Pardon me?

Mr. FIELD. We vigorously support that. Our concern relates to those regulations and those encumbrances that presently are hindering development of HMO concept, and that is, I think, obvious to your committee.

HMO's have not come forward and developed as rapidly as you hoped. One of the reasons, we feel, is because of the encumbrances that have been put on them by this requirement.

Senator NELSON. I think you may very well be right. There are some provisions that ought to be modified.

But, still, the heart of the matter is the open enrollment, it seems to me, and if all we are going to do is have insurance plans in this country for healthy people, we might as well forget the whole business.

So I go back to my question. If, in fact, it is a competitive handicap for the HMO, and I am not even sure it is, but if it is for a new HMO—and you seem to indicate that you are concerned about the new HMO because your language referred to fledgling HMO's some place there—if that is the case then, why would we have to have a statute that eliminates that requirement? Why could you not provide that, for the first 2 years or some such thing, the new HMO may use experience rating but then must have open enrollment, so that they are taking care of sick people as well as healthy people?

Mr. FIELD. Well, Senator. I think there is also a concern that presently we are requiring, imposing through open enrollment an encumbrance on the HMO's that its competitors, in terms of delivery systems, insurance companies and indemnity companies, are not directly confronted with. So that some of these other organizations will, in effect, be in a preferred relationship to the HMO that is encumbered with total open enrollment.

Senator NELSON. Well, I hope you will take a look at the testimony of the only HMO in this country with 5 years experience with open enrollment in a very, very large operation with a very large number of patients, which is working very, very well.

We know what the experience of this HMO is. It is not on a small scale. Yes; 140 doctors is a very large scale. They defend it and favor it and support it because they are trying to take care of everybody in the whole geographic community in which they operate.

Within the geographic dimension of the HMO, there is open enrollment twice a year for 30 days, and it has been very successful. They are not selecting just sick people, so I think you ought to look at that.

I am a great believer in empirical studies. Theory is one thing. We have an example of an operating organization that proves open enrollment works. The argument is always made the way you make it, and it sounds very logical, but here is a very large experimental case in which it is working very well.

I would oppose any bill that eliminated open enrollment. There might be some provision exempting a brand new HMO.

As far as I am concerned, that would be a disaster for delivery of health care in this country.

Ms. WOODEN. May I comment?

The Marshfield plan is the exception, though, and it is precisely because it is so large and it has such a large enrollment that perhaps that is the reason they have been able to absorb this very high risk.

But for a small HMO that is just getting started, fewer doctors than 140, and many of the newer HMO's will have considerably less numbers of doctors than 140, they will not be able to absorb this high risk perhaps initially. And to give them a waiver of 2 or 3 years might not be enough for them to take the risk to start a HMO, which is a very large undertaking, if they know within 2 or 3 years their business is just getting going, and all of a sudden they have to support this tremendous added burden, they might not ever want to even pursue the venture.

That is why we are opposed to open enrollment provision at this time.

Senator NELSON. On the other hand, if you are not going to have open enrollment, why bother at all?

Who is going to take care of the people who are sick?

Ms. WOODEN. I do not think anyone opposes the concept of open enrollment, taking care of the sick. No one wants to disallow a person seeking medical care the choice of the HMO or the insurance plan.

But just to prejudice HMO at this time perhaps would stifle the growth of them. I think we all favor the growth of the HMO movement.

Senator NELSON. Well, as I understand, you favor taking care of the sick, as I know you do, and you favor open enrollment, but you are concerned about new and smaller HMO's.

Then I take it, at least, you do not support the concept of eliminating entirely a provision that requires open enrollment, and that you would be prepared to consider some modification as it might apply to fledgling HMO's and smaller ones. Is that a correct interpretation of what you are saying?

Ms. WOODEN. Our chief concern is to allow these things to get started and let them grow and compete and give people the choice in preventive health care system or regular traditional health insurance indemnity system. That is what the whole thrust of our testimony is, to allow HMO's to get started.

Senator NELSON. But to get to the specific point: that does not require the elimination of the open enrollment provision. I take it you must be saying, if I read this testimony and your responses correctly, that some modification of the open enrollment to meet your concern about the fledgling HMO and small HMO would satisfy the concern that has been expressed in the prepared testimony and your own; am I correct?

Ms. WOODEN. I think you are correct in that. We are agreeable people. We would certainly consider some modification that again would take into consideration placing the excessive hardship on the HMO, but I do not know what your specific modification might be.

Senator NELSON. The prepared testimony, formal testimony, of Mr. Field shows concern about new ones being competitive, concern about the fledglings, concern about the new ones coming in.

My response to that is, if that is a valid concern, and it may well be—we have not had oversight hearings to determine all of that, but let us assume that is valid—that is your concern as is expressed in the testimony. I am saying, therefore, that it is not necessary to eliminate the requirement for open enrollment, but it may be necessary to modify

the open enrollment provision respecting new HMO's for a limited period of time.

Now, do you agree with that?

Ms. WOODEN. I would have to really see the modification you are proposing.

Senator NELSON. I am asking you about the concept.

Your expression of concern has been about the new HMO, the smaller HMO, and the formal testimony here and your testimony was, "Well, Marshfield is a very big operation. Therefore, they do not have trouble."

So I go back to my question, because I would like to know when we debate the issue on the floor, when we mark up the bill here, when we go to conference with the House, I would like to be precise.

Now, I would not expect you to agree on whether it would be 1 year, 2 years, or this or that. I am just asking you, would you agree then with the concept that you not eliminate the open enrollment provision in the statute, but there be some modification to meet the problem of the fledgling HMO for some limited period of time in order that they may, as Mr. Field said in his testimony, compete with other health insurance companies?

Mr. FIELD. I would think, Senator, that we are all saying basically the same thing, except somewhere down the road there may be a viable size operationally for HMO when it then could adapt to very readily the open enrollment concept.

Our concern is at the moment that new HMO's, beginning to be set up, that poses tremendous difficulty on them since they are to compete against organizations that are not encumbered the same way.

Senator NELSON. I would not expect anyone to approve a specific proposal to meet the specific problem that you have delineated off the top of your head and on first impression. But that is not my question.

My question just goes to the concept, one, of preserving open enrollment; but two, taking into consideration the problem of the new HMO from a competitive standpoint, the problem you delineated and the problem of the smaller HMO for a limited period of time until they are established and growing, whether that modification involves a specific period limitation, whether it involves a number—well, I am just trying to get at the question of whether you endorse the concept so I will be able to respond to the question: Where does the chamber of commerce stand on the issue?

Ms. WOODEN. I think that our testimony which says that Congress should look to equitable solution whereby both insurers and HMO's would share this risk for open enrollment might be something that we really should study so that people, whether they chose HMO or whether they chose indemnity, Blue Cross/Blue Shield, would all have the same protection of knowing that they would be able to get health care coverage, health care insurance coverage.

I think this is the line that we should be taking and that the chamber would support.

Senator NELSON. I think the idea is nice, but to accomplish that, I am sure you are aware, we would have to pass a statute requiring the private insurers to share that risk, and I would like to have you then here answering the private insurers when they come in to fight that.

Ms. WOODEN. We are in the process of considering the statute to re-

quire HMO to take this risk on unilaterally, and it is the same process. I do not know that you can really distinguish these two.

Senator NELSON. I should have remembered that there is in the law, as the staff calls to my attention, already a provision that if an HMO has demonstrated to the satisfaction of the Secretary, (a) that it has enrolled or will be compelled to enroll a disproportionate number of individuals who are likely to utilize its services more often than actuarially determined average, as determined under regulations of the Secretary, and enrollment during open enrollment period of additional number of such individuals would jeopardize its economic viability; or (b) if by maintaining an open enrollment period, it would not be able to comply with the requirements in paragraph 3, the Secretary may waive compliance by the organization.

So there is administrative flexibility in the statute now.

Ms. WOODEN. But it is a waiver, sir, and a waiver is not nearly as strong as having it in the law that they are not required to meet this provision.

Senator NELSON. Let us be specific about that.

You are saying in your testimony, prepared testimony, that maybe private insurers and HMO's should share the risks.

Would the U.S. Chamber of Commerce support an amendment to the statute that required private insurers to share the risk with the HMO?

Mr. FIELD. I doubt if we are prepared to answer that question directly.

We have given no thought to such a requirement.

Senator NELSON. It would not work if you did not. It is a nice concept, Mr. Field, to say it would be a good thing to work out, a cooperative arrangement between private insurer and the HMO, in which they could share the risk. I agree with you, but it is not going to be done without the private insurer being required, which I do not think at this stage in history we would probably pass, and surely they would oppose it.

Mr. FIELD. There may be some alternative down the road in terms of size of time that would be applied to this open enrollment concept.

At the moment, as we see it emerging, the new HMO's that are attempting to get going have a real handicap. They must go for open enrollment right from the start.

Senator NELSON. Go ahead, Mr. Field.

Mr. FIELD. I will start at the top of page 4.

Section 7: The chamber generally supports the provision which would allow physicians whose principal professional activity is in group practice to participate in HMO practice regardless of whether or not such physician devotes the majority of his time to the HMO practice.

Arbitrarily forcing doctors to spend a majority of their time in HMO practice could stifle the growth of HMO's by placing necessary restrictions on physician group practice. Many companies are already satisfactorily dealing with HMO's and have found that market demand is the most effective determinant of the amount of time a physician should spend in an HMO practice. Absent this provision, some of the country's greatest group practice associations, such as the Mayo Clinic

and the Cleveland Clinic, will never find it practical to open up an ancillary HMO facility.

Section 11: The chamber supports establishment of a procedure for disqualification of HMO's offering the section 1310 dual choice option. Employers dealing with HMO's also need a method of appeal to the Department of Health, Education, and Welfare—HEW—when an initially qualified HMO no longer warrants such status.

The HMO's method of enrollment, quality of care, medical staff turnover or solvency may make reevaluation necessary despite an earlier "qualified" endorsement by HEW. An employer could find himself in the untenable position of having to offer an HMO that is not properly serving his employees.

Mr. Chairman, we believe that these amendments are essential if HMO's are to survive on their own merits. They are consistent with the American business traditions of freedom of choice, incentive approaches for efficiency, self-reliance and competition. HMO's are not designed to be a system for solving all the problems of health care delivery in this country. HMO's are a small pilot demonstration program designed to inject a competitive system of delivering preventive medical care into our existing health delivery system.

The proposed modification of the benefit structure may produce a benefit package that falls short of ideal and short of that initially envisioned by the Congress. We recognize there will be those who argue against HMO program modifications at this stage because the original act has not been fully implemented.

We question whether the HMO movement will ever be fully implemented if the amendments are not agreed to. In this matter, as in other aspects of health care delivery, we must learn to temper our idealism with realism. Health care resources are unfortunately finite, and so are the dollars available to purchase them.

In a start-up program, we must make some hard choices between what would be ideal and what is essential.

The business community shares all the concerns about drug abuse, inadequate home health care, preventive care for children and, in general, the desirability of a totally comprehensive benefit package. Such total protection is a worthwhile endeavor.

The Chamber supports the concept of comprehensive benefit coverage and universal access to health care for all Americans; but we should not confuse HMO's with an all-encompassing national health insurance system which would address all the health needs of the country. HMO's are not designed to do that. They do not have the resources to presently meet all of our expectations.

Today, we are simply trying to make the HMO competitive with third-party insurance systems, and no more than that. The purpose of the HMO program should therefore be to produce a viable alternative to other health care arrangements.

We believe that HMO's should be allowed to compete with existing health care delivery schemes. We will destroy the whole purpose behind the HMO movement if we force HMO's to offer a benefit package without regard to the total cost involved. Likewise, if we ignore the market pressures and demands which determine the amount of time physicians devote to HMO practices, and ignore the problems open en-

rollment and community rating create for beginning HMO's, we may undermine the basic purpose of the act.

We strongly support the intent of the legislation to create prepaid systems of preventive health care for individuals and families, particularly those with young children. Our citizens need the security of knowing in advance how much must be provided in the family budget for adequate protection against illness.

The American people need a choice as to how they receive health care. Passage of S. 1926 will make HMO's a realistic choice. HMO's have demonstrated the potential to counteract the upward spiral in health care costs with the least intrusion by the Federal Government in the private practice of medicine.

Surveys have shown that, when compared with fee for service care, HMO participants receive better and less costly outpatient care, and spend less time in hospitals when hospitalization is necessary. Increased Federal subsidies of health care cost without substantial improvement in the effectiveness of the delivery system will only accelerate the alarming rate of increase in medical costs.

Most Americans still appreciate the advantages of a plurality of choice of health care. The choice of group practice, fee-for-service, or some modified plan depends on personal feelings, economic status, or geographic locations. HMO's are not a panacea, or even suitable for everyone, but they need to be developed as one way of injecting more competition into the delivery of health care services.

In the future, when more HMO's are on a sound footing, it may be appropriate to consider expansion of the benefits and the standards required of HMO's. At the present time, fledgling HMO's need a chance merely to survive.

Mr. Chairman, this concludes my prepared remarks. We look forward to working with you and your colleagues in shaping this legislation which will improve the opportunity to experiment with an alternative health care delivery system, increase incentives for health care providers to become more efficient and competitive, and assist employers in offering the dual choice option to their employees.

I will be pleased to answer any questions after my associate, David F. McIntire, has the opportunity to present his testimony on the experience of General Mills, Inc. with the HMO movement.

Senator NELSON. Thank you very much, Mr. Field. We appreciate your statement and your taking the time to come here today to present it.

Mr. McIntire.

Mr. McINTIRE. Good morning, Senator.

My name is David F. McIntire. I am employee benefits manager for General Mills, Inc., headquartered in Minneapolis, Minn. I am a member of the chamber's Special Committee on the Nation's Health Care Needs and serve as chairman of its Subcommittee on Health Delivery Systems.

General Mills supports the chamber's position as summarized by Mr. Field in amending the Health Maintenance Organization Act of 1973. These amendments would allow developing health maintenance organizations, HMO's, to better compete in the marketplace with the traditional fee-for-service system.

As Mr. Field indicated, I will comment on General Mills' experience to date in offering the HMO option to its salaried employees. In addition, I will comment briefly on the favorable HMO activity in the Twin Cities of Minneapolis and St. Paul, as I believe it is unique in the country.

General Mills first became interested in the prepaid group practice concept in the late 1960's. Two major factors accounted for the company's interest.

First, there was a genuine concern about the spiraling costs of medical care under the traditional fee-for-service health care system and, second, there appeared to be the potential for better control of health care costs under the prepaid group practice concept.

General Mills continued its investigation of the prepaid group practice concept during the early 1970's and, on March 1, 1973, it made the HMO option available to its Minneapolis area employees on a pilot project basis. In the initial enrollment, 535—20.3 percent—of 2,640 eligible employees joined the HMO plans. I should point out here that the employees who joined the HMO plan were required to make a monthly contribution of \$6 for single and \$8 for family coverage, whereas the company provides employee and dependent coverage under its indemnity health plan at no cost to employees.

Our second enrollment period for employees was held in December 1973, and the number of General Mills' HMO members increased to 844, or 31.2 percent, of the eligible employees. Only three of the initial General Mills' HMO members chose to switch back to the company indemnity health plan. The increase in membership was attributed primarily to the favorable comments of the initial HMO plan members as General Mills purposely takes an unbiased position in presenting its indemnity plan and the HMO option to its employees.

The third employee enrollment period was held in December 1974. General Mills' HMO membership increased again, this time to 1,127 members or 40.8 percent of eligible employees. If we include the employees' dependents, we have approximately 3,500 members in the HMO plan. Employee satisfaction remained high as only six HMO members switched back to the company's indemnity health plan on January 1, 1975.

We are holding our fourth employee open enrollment meeting this week for our Minneapolis employees for calendar 1976. As part of the 1976 offering General Mills has added a second HMO plan option as the company believes competition between HMO's is a desirable way to bring market forces to bear on the health industry.

It will be several weeks before we have the final enrollment results although we expect the percentage of HMO members to increase somewhat more due to the addition of the second HMO option and a reduction in the fee charged for HMO participation.

Senator NELSON. Is that elimination of the fee for both options?

Mr. McINTIRE. That is correct.

Senator NELSON. And which of the two options, the first or second, is the highest option in benefits?

Mr. McINTIRE. No.

With respect to this, I mean an option, Nicollet Clinic, and option with St. Louis Park Clinic.

Senator NELSON. Same benefit levels?

Mr. McINTIRE. Yes.

I think it is important to note that the physician groups, the St. Louis Park Medical Center—established in 1952 which now has some 75 physicians—and the Nicollet—established in 1921 and now has about 35 physicians—that are providing the medical services for the two HMO plans available to General Mills employees are basically fee-for-service groups.

Approximately 95 percent of the Nicollet Clinic's and 90 percent of the St. Louis Park Medical Center Clinic's business is on the fee-for-service basis. This points out, to me, the need to postpone—as section 7 of S. 1926 would do—the requirement that the principal professional activity of members of a medical group be HMO services.

The HMO principal activity provision in the HMO Act of 1973 is of real concern to existing well-established fee-for-service group practices that wish to offer HMO plans, and it is of real concern to companies, such as General Mills, that wish to offer high quality HMO plans which may only be available from principally fee-for-service physician groups.

Minneapolis employees at General Mills will not be required to make contributions for HMO coverage during 1976 since HMO costs and the company indemnity plan costs are now, for all practical purposes, the same.

We are in favor of providing reasonable benefits but we do not think that HMO plans should be required to provide numerous expensive supplemental benefits that will render them noncompetitive with the traditional group insurance and service organization plans. These typically have built-in safeguards, such as waiting periods, deductibles, varying coinsurance factors, specific exclusions, and maximum benefits amounts.

A very brief overview of the benefit coverages of the General Mills indemnity plan and its two Minneapolis HMO option plans is attached as exhibit A to copies of these remarks.

General Mills' experience with high participation in the HMO option plan is not unique. Other Minneapolis companies have also experienced participation rates in the 30- and 40-percent range.

The overall general acceptance of HMO's in the Minneapolis and St. Paul area—there are seven operational HMO plans now—is the result of a number of different factors with the major one being the educational effort that has been made by the Twin Cities health care development project.

The local business community believed that HMO development might benefit from a professionally staffed, independent and broad-based organization that would evaluate an alternative form of health care delivery and generally provide support for the HMO movement.

In addition, the new Twin Cities HMO's have been created from some of the finest fee-for-service group practices in the United States. We have learned from this experience that the two modes for health care practice can be readily combined.

Since 1972 HMO activity in the Twin Cities has grown substantially. The seven metropolitan HMO's serve over 95,000 residents—more than double the enrollment when the project began. Five of the project's sponsoring companies have offered the HMO option locally and two

more are planning to add HMO options within the next several months.

General Mills decided to continue its experiment and not to wait for the issuance of final section 1310 regulations before making the HMO option available at several other company locations.

An HMO plan was offered at two General Mills locations in California on January 1, 1975, and two HMO plans were made available to employees in the Greater Chicago area on July 1, 1975. Our enrollment experiences were disappointing and were in no way similar to our experience in Minneapolis. Only 5 percent of the eligible California employees chose the HMO option, and only 1 percent chose the option in Chicago.

We are not positive what factor or combination of factors account for the enrollment results in California and Chicago, but we suspect that employees' monthly out-of-pocket which were higher than the Minneapolis employees' out-of-pocket HMO costs, seemed high to employees who were already satisfied with the company-paid indemnity health plan.

Senator NELSON. The cost to the employee in Chicago and California was higher than in Minneapolis?

Mr. McINTIRE. Yes, because we use our company indemnity plan as base, and because of regional differences in costs for medical services across the country, there is higher cost on the west coast, and so in using the base cost for company indemnity plan, they had to make up the difference between that and the cost of the HMO.

The HMO cost in California was considerably more than it was in Minneapolis.

Senator NELSON. Did I understand you to say earlier on that the individual cost was \$6 in addition to your indemnity plan in Minneapolis and \$8 for—

Mr. McINTIRE. \$6 for single and \$8 for family in Minneapolis, for calendar year that is ending, and beginning next calendar year in Minneapolis, there will be no employee contribution for HMO coverage.

Senator NELSON. Will that be the same option you are offering in California?

Mr. McINTIRE. They will be making up the differences in those costs, as those plans come to renewal date. It may very well be that our employees outside of Minneapolis area will still be required to pay an out-of-pocket cost for HMO coverage.

Senator NELSON. Proceed.

Mr. McINTIRE. The employees were not as familiar and knowledgeable about HMO's as were our Minneapolis employees, resulting in possible suspicion of "second class" health care; and the employees may not have found the locations of the HMO clinics and hospitals as convenient as their existing sources of medical care under the indemnity health plan.

Even with the disappointing enrollment results in California and Chicago, General Mills supports the HMO concept and plans to continue to offer proven high-quality nonqualified HMO plans to its employees where there are no federally qualified HMO plans and possibly will offer, in certain areas, proven high quality nonqualified HMO plans in addition to federally qualified plans.

Overall, I would have to say that General Mills experience with the HMO option has been successful, particularly so in Minneapolis. As I

mentioned earlier, the option was offered on a pilot project basis to determine, if possible, whether quality care could actually be provided under a better controlled cost basis, as proponents of the prepaid group practice concept claimed.

Although General Mills has only had the HMO option for approximately 3 years, it can report to date that, as a whole, members have received quality health care and HMO plan costs have not increased as rapidly as our and other group health indemnity plan costs in Minneapolis and St. Paul.

According to one Minneapolis-based insurance company, rate increases for indemnity health plans on average are up approximately 25 percent to 30 percent in the Twin Cities area compared to HMO plan average rate increases of 12 percent to 15 percent.

Recent comparisons between HMO and the General Mills medical insurance plan indicate that the HMO plans have a substantially lower hospital utilization rate.

Senator NELSON. Let me ask a question.

That differential between indemnity health plans, which are up 25, 30 percent, and HMO 12 to 15 percent, and your HMO is on a fee-for-service basis?

Mr. McINTIRE. No.

The group of physicians that are providing the HMO services are basically providing 95 percent of their services on a fee for service. It is a split operation.

Senator NELSON. There is not a fee-for-service charge under HMO?

Mr. McINTIRE. That is right.

Senator NELSON. I misunderstood you earlier.

Mr. McINTIRE. The Med Center health plan, the first HMO offered by General Mills, has a record of 400 days of hospital confinement per 1,000 people. The Nicolett plan confinement rate ranges from 500 to 625 hospital days per 1,000 people, not as favorable primarily because of its relatively small membership—less than 3,000—therefore, the percentage rate is more susceptible to fluctuation. The hospital utilization rate is expected to level off as the membership increases.

In sharp contrast to the HMO plans, the General Mills medical insurance plan hospital utilization rate has been approximately 780 hospital days per 1,000 people. Daily hospital rates in the Minneapolis area are as high as \$115 for obstetrical procedures through \$150 for surgical procedures to \$290 for intensive care.

General Mills has been pleased with its experience in offering the HMO option for a number of reasons, including:

The HMO option is perceived by our employees and their families as an important part of the company's overall employee benefit package. The HMO option provides our employees with a choice between company indemnity plan and HMO plan benefits, and a choice between fee-for-service and prepaid group practice health care delivery systems.

The prepaid group practice HMO option provides our employees with a central source of quality comprehensive health care and services on a 24-hour basis.

The HMO plan provides a readily available source of professional health care for our company employees who are transferred to Minneapolis from other parts of the country; there are no problems in find-

ing a new doctor, and plan members' medical costs are reasonably well-defined and budgeted in advance of any necessary care that they receive under the plan during the course of the year.

In summary, General Mills is pleased with the HMO option. Our satisfaction is based on the quality of care rendered, expressed employee satisfaction, and preliminary indications that costs of health care under HMO's may be contained better than under the traditional fee-for-service system.

General Mills supports, as does the chamber, S. 1926, and hopes that it does become law, thereby allowing existing and new HMO plans to compete on a more favorable basis with the traditional group health insurance and service organization plans.

Mr. Chairman, I will be happy to answer any questions that there may be with respect to General Mills' experience in offering the HMO option to its employees.

Senator NELSON. Thank you very much, Mr. McIntire.

I will forego any questions at the moment because of the interruptions we are going to have with rollcalls.

We want everyone to have an opportunity to get their testimony in the record.

However, would you gentlemen be willing to respond to questions if committee members have questions they would like to submit to you in writing, and the record will be kept open?

Mr. McINTIRE. We would.

Senator NELSON. Thank you very much.

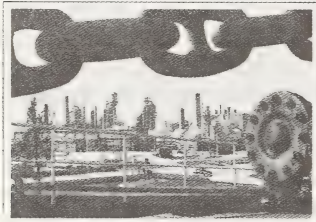
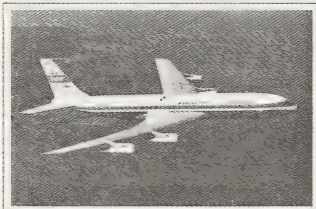
Ms. WOODEN. May I ask a question?

Senator NELSON. Yes.

Ms. WOODEN. Will our testimony be included in the record with our exhibits?

Senator NELSON. Everything in your prepared text, as well as your extemporaneous remarks, will be included in the record.

[The prepared statement of Mr. Field, presented on behalf of the Chamber of Commerce of the United States, follows:]



Statement of the

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA

on: Health Maintenance
Organization Amendments
of 1975, S. 1926

to: Subcommittee on
Health, Senate
Committee on Labor
& Public Welfare

by: Edward L. Field
& David E. McIntire

date: December 12, 1975



As the nation's largest business federation, the Chamber's membership includes over 48,000 business firms, corporations and individuals—and more than 3,500 chambers of commerce and trade and professional associations, with an underlying membership in excess of 5,000,000.

STATEMENT
on
HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1975 (S.1926)
before the
SUBCOMMITTEE ON HEALTH
of the
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE
for the
CHAMBER OF COMMERCE OF THE UNITED STATES
by
EDWARD L. FIELD and DAVID F. MCINTIRE
December 12, 1975

My name is Edward L. Field. I am Operating Vice President of Employee Relations for Federated Department Stores, Inc., headquartered in Cincinnati, Ohio. I was a member of the Chamber's Special Committee on the Nation's Health Care Needs for several years, and chaired its subcommittee on Health Delivery Systems.

My associate today is David F. McIntire, Manager of Employee Benefits, General Mills, Inc., headquartered in Minneapolis, Minnesota, and a member of the Chamber's Health Committee.

Accompanying us is Rose P. Wooden, Committee Executive of the Chamber's Special Committee on The Nation's Health Care Needs.

The Chamber welcomes this opportunity to support S.1926, The Health Maintenance Organization Amendments of 1975. This issue is of vital concern to our membership which embraces more than 48,000 business enterprises, 3,600 trade and professional associations and local and state chambers of commerce. The underlying membership is more than 5,000,000 individuals and firms.

The Chamber supported the original HMO Act which encompassed the concept of pilot-testing. We recognized the need to experiment with alternative methods of health care delivery. The business community keenly hopes that the HMO system will prove to be a means to effectuate reasonable constraints on the spiralling cost of health care.

Our concern is that HMOs have not developed as rapidly as we expected when the Act was signed into law two years ago. We have found that certain provisions of the Act are administratively impractical, from the point of view of both an employer and an HMO provider. Other provisions tend to make HMOs not competitive with existing health care programs. Instead of encouraging the growth of HMOs, the richness of the statutory benefit packages and certain of the organizational and operating procedures are acting as real deterrents.

We believe that S.1926 was introduced to alleviate these problems. We commend this committee for considering proposed amendments, many of which we find to be constructive.

The Chamber's specific comments on eight substantive amendments contained in S.1926 follow in the order of their importance to business:

--Section 10

The most serious problem for employers raised by the original Act was the provision that a qualified HMO must be recognized by the Employer for the dual choice option, even if only one employee resides in that HMO's service area. This provision places an extremely heavy administrative burden on employers. Applying the 25 employee requirement in Section 1310 to the HMO service area would relieve this problem.

The Chamber supports deletion of criminal penalties for employers who fail to offer the HMO option. We favor the substitution of civil penalties assessed by the Secretary of Health, Education and Welfare.

--Section 5

We support reduction in the required benefit package to be offered by HMOs. Business is concerned that the HMO option be cost-competitive with the current company health benefit plans. Further, it has been difficult for employers to determine the cost of individual HMO services beyond those offered by the company plan. Reducing the required benefit package to levels comparable to existing employee benefit plans will enable employers to determine their cost contribution to the

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HMO plan more easily. Adoption of the HMO concept will be increased by such a reduction in the level of required benefits. Otherwise, HMOs are put in a position of pricing themselves out of the market.

--Section 2 The Chamber supports making supplementary benefit schedules optional for HMOs, if health manpower is available and if the market can bear the additional costs. This provision would make the operation of HMOs more realistic.

--Section 6 Regarding community rating, we believe HMOs should be able to market their product competitively with indemnity or Blue Cross/Blue Shield plans. Normally, many indemnity and Blue Cross/Blue Shield plans are experience-rated. We believe the amendment which would delay community rating should be strengthened to allow HMOs to experience-rate in keeping with the traditional marketing procedure of major insurers and Blue Cross/Blue Shield plans.

--Section 4 We generally support deletion of the requirement for an annual open enrollment. It is recognized that the intent of the Act is to remove barriers to enrolling in the alternative HMO plans. However, to allow fledgling HMOs to get started they should be allowed to compete on an equal basis with health insurance plans. The mechanism of placing open enrollment unilaterally on HMOs is prejudicial because it exposes HMOs to a greater proportion of high medical risk candidates. The Chamber is sympathetic to making relief available for persons with high medical risks, but opposes placing an excessive burden on one small share of the health industry. Congress should look to an equitable solution whereby both insurers and HMOs would share this risk of open enrollment.

--Section 3 The Chamber generally supports allowing individual practice association (IPAs) to continue their customary practice of providing HMO services directly to enrollees through arrangements with physicians and health care providers.

--Section 7

The Chamber generally supports the provision which would allow physicians whose principal professional activity is in group practice to participate in HMO practice regardless of whether or not such physician devotes the majority of his time to the HMO practice. Arbitrarily forcing doctors to spend a majority of their time in HMO practice could stifle the growth of HMOs by placing unnecessary restrictions on physician group practice. Many companies are already satisfactorily dealing with HMOs and have found that market demand is the most effective determinant of the amount of time a physician should spend in an HMO practice. Absent this provision, some of the country's greatest group practice associations such as the Mayor Clinic and the Cleveland Clinic will never find it practical to open up an ancillary HMO facility.

--Section 11

The Chamber supports establishment of a procedure for disqualification of HMOs offering the Section 1310 dual choice option. Employers dealing with HMOs also need a method of appeal to the Department of Health, Education and Welfare (HEW) when an initially qualified HMO no longer warrants such status. The HMOs method of enrollment, quality of care, medical staff turnover or solvency may make re-evaluation necessary despite an earlier "qualified" endorsement by HEW. An employer could find himself in the untenable position of having to offer an HMO that is not properly serving his employees.

Mr. Chairman, we believe that these amendments are essential if HMOs are to survive on their own merits. They are consistent with the American business traditions of freedom of choice, incentive approaches for efficiency, self-reliance and competition. HMOs are not designed to be a system for solving all the problems of health care delivery in this country. HMOs are a small pilot demonstration program designed to inject a competitive system of delivering preventive medical care into our existing health delivery system.

The proposed modification of the benefit structure may produce a benefit package that falls short of ideal and short of that initially envisioned by the Congress. We recognize there will be those who argue against

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HMO program modifications at this stage because the original act has not been fully implemented. We question whether the HMO movement will ever be fully implemented if the amendments are not agreed to. In this matter, as in other aspects of health care delivery, we must learn to temper our idealism with realism. Health care resources are unfortunately finite, and so are the dollars available to purchase them. In a start-up program, we must make some hard choices between what would be ideal and what is essential.

The business community shares all the concerns about drug abuse, inadequate home health care, preventive care for children and, in general, the desirability of a totally comprehensive benefit package. Such total protection is a worthwhile endeavor. The Chamber supports the concept of comprehensive benefit coverage and universal access to health care for all Americans; but we should not confuse HMOs with an all encompassing national health insurance system which would address all the health needs of the country. HMOs are not designed to do that. They do not have the resources to presently meet all of our expectations. Today, we are simply trying to make the HMO competitive with third-party insurance systems, and no more than that. The purpose of the HMO program should therefore be to produce a viable alternative to other health care arrangements.

We believe that HMOs should be allowed to compete with existing health care delivery schemes. We will destroy the whole purpose behind the HMO movement if we force HMOs to offer a benefit package without regard to the total cost involved. Likewise, if we ignore the market pressures and demands which determine the amount of time physicians devote to HMO practices, and ignore the problems open enrollment and community rating create for beginning HMOs, we may undermine the basic purpose of the Act.

We strongly support the intent of the legislation to create pre-paid systems of preventive health care for individuals and families, particularly those with young children. Our citizens need the security of knowing in advance how much must be provided in the family budget for adequate protection against illness. The American people need a choice as to how they receive health care. Passage of S.1926 will make HMOs a realistic choice. HMOs have demonstrated the potential to counteract the upward spiral in health care costs with the least intrusion by the federal government in the private practice of medicine.

Surveys have shown that, when compared with fee for service care, HMO participants receive better and less costly outpatient care, and spend less time in hospitals when hospitalization is necessary. Increased federal subsidies of health care cost without substantial improvement in the effectiveness of the delivery system will only accelerate the alarming rate of increase in medical costs.

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In the future, when more HMOs are on a sound footing, it may be appropriate to consider expansion of the benefits and the standards required of HMOs. At the present time, fledgling HMOs need a chance merely to survive.

Mr. Chairman, this concludes my prepared remarks. We look forward to working with you and your colleagues in shaping this legislation which will improve the opportunity to experiment with an alternative health care delivery system, increase incentives for health care providers to become more efficient and competitive, and assist employers in offering the dual choice option to their employees.

I will be pleased to answer any questions after my associate David F. McIntire has the opportunity to present his testimony on the experience of General Mills, Inc. with the HMO movement.

My name is David F. McIntire, I am Employee Benefits Manager for General Mills, Inc. headquartered in Minneapolis, Minnesota. I am a member of the Chamber's Special Committee on the Nation's Health Care Needs and serve as chairman of its Subcommittee on Health Delivery Systems.

General Mills supports the Chamber's position as summarized by Mr. Field in amending the Health Maintenance Organization Act of 1973. These amendments would allow developing health maintenance organizations (HMOs) to better compete in the marketplace with the traditional fee-for-service system.

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General Mills continued its investigation of the prepaid group practice concept during the early 1970s and on March 1, 1973 it made the HMO option available to its Minneapolis area employees on a pilot project basis. In the initial enrollment, 535 (20.3%) of 2,640 eligible employees joined the HMO plan. I should point out here that the employees who joined the HMO plan were required to make a monthly contribution of \$6 for single and \$8 for family coverage, whereas the Company provides employee and dependent coverage under its indemnity health plan at no cost to employees.

Our second enrollment period for employees was held in December 1973 and the number of General Mills HMO members increased to 844, or 31.2% of the eligible employees. Only three of the initial General Mills HMO members chose to switch back to the Company indemnity health plan. The increase in membership was attributed primarily to the favorable comments of the initial HMO plan members as General Mills purposely takes an unbiased position in presenting its indemnity plan and the HMO option to its employees.

The third employee enrollment period was held in December, 1974. General Mills' HMO membership increased again, this time to 1,127 members or 40.8% of eligible employees. If we include the employees' dependents, we have approximately 3,500 members in the HMO plan. Employee satisfaction remained high as only six HMO members switched back to the Company's indemnity health plan on January 1, 1975.

We are holding our fourth employee open enrollment meeting this week for our Minneapolis employees for calendar 1976. As part of the 1976 offering, General Mills has added a second HMO plan option as the company believes competition between HMOs is a desirable way to bring market forces to bear on the health industry. It will be several weeks before we have the final enrollment results although we expect the percentage of HMO members to increase somewhat more due to the addition of the second HMO option and a reduction in the fee charged for HMO participation.

I think it is important to note that the physician groups, the St. Louis Park Medical Center (established in 1952 which now has some 75 physicians) and the Nicollet (established in 1921 and now has about 25 physicians), that are providing the Medical services for the two HMO plans available to General Mills employees are basically fee-for-service groups. Approximately 95% of the Nicollet Clinic's and 90% of the St. Louis Park Medical Center Clinic's business is on the fee for service basis. This points out, to me, the need to at least postpone (as Section 7 of S. 1926 would do) the requirement that the principal professional activity of members of a medical group be HMO services. The HMO principal activity provision in the HMO Act of 1973 is of real concern to existing, well-established fee-for-service group practices that wish to offer HMO plans and it is of real concern to companies such as General Mills that wish to offer high quality HMO plans which may only be available from principally fee-for-service physician groups.

Minneapolis employees at General Mills will not be required to make contributions for HMO coverage during 1976 since HMO costs and the company indemnity plan costs are now, for all practical purposes, the same.

We are in favor of providing reasonable benefits but we do not think that HMO plans should be required to provide numerous expensive supplemental

benefits that will render them non-competitive with the traditional group insurance and service organization plans. These typically have built-in safeguards such as waiting periods, deductibles, varying co-insurance factors, specific exclusions and maximum benefit amounts.

A very brief overview of the benefit coverages of the General Mills indemnity plan and its two Minneapolis HMO option plans is attached as Exhibit A to the copies of these remarks.

General Mills' experience with high participation in the HMO option plan is not unique. Other Minneapolis companies have also experienced participation rates in the 30% and 40% ranges.

The overall general acceptance of HMOs in the Minneapolis and St. Paul area (there are seven operational HMO plans now) is the result of a number of different factors with the major one being the educational effort that has been made by the Twin Cities Health Care Development Project. The local business community believed that HMO development might benefit from a professionally staffed, independent and broad-based organization that would evaluate an alternative form of health care delivery and generally provide support for the HMO movement. In addition, the new Twin Cities HMOs have been created from some of the finest fee-for-service group practices in the U. S. We have learned from this experience that the two modes for health care practice can be readily combined.

Since 1972, HMO activity in the Twin Cities has grown substantially. The seven metropolitan HMOs serve over 95,000 residents -- more than double the enrollment when the Project began. Five of the Projects's sponsoring companies have offered the HMO option locally and two more are planning to add HMO options within the next several months.

General Mills decided to continue its experiment and not to wait for the issuance of final Section 1310 regulations before making the HMO option available at several other Company locations.

An HMO plan was offered at two General Mills locations in California on January 1, 1975 and two HMO plans were made available to employees in the greater Chicago area on July 1, 1975. Our enrollment experiences were disappoint-

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ing and were in no way similar to our experience in Minneapolis. Only 5% of the eligible California employees chose the HMO option and only 1% chose the option in Chicago.

We are not positive what factor or combination of factors account for the enrollment results in California and Chicago but we suspect that: employees' monthly out-of-pocket costs, which were higher than the Minneapolis employees' out-of-pocket HMO costs, seemed high to employees who were already satisfied with the Company-paid indemnity health plan; the employees were not as familiar and knowledgeable about HMOs as were our Minneapolis employees, resulting in possible suspicion of "second class" health care; and the employees may not have found the locations of the HMO clinics and hospitals as convenient as their existing sources of medical care under the indemnity health plan.

Even with the disappointing enrollment results in California and Chicago, General Mills supports the HMO concept and plans to continue to offer proven high quality non-qualified HMO plans to its employees where there are no Federally qualified HMO plans and possibly will offer, in certain areas, proven high quality non-qualified HMO plans in addition to Federally qualified plans.

Overall, I would have to say that General Mills experience with the HMO option has been successful, particularly so in Minneapolis. As I mentioned earlier, the option was offered on a pilot project basis to determine, if possible, whether quality health care could actually be provided under a better controlled cost basis, as proponents of the prepaid group practice concept claimed. Although General Mills has only had the HMO option for approximately three years, it can report to date that as a whole, members have received quality health care and HMO plan costs have not increased as rapidly as our and other group health indemnity plan costs in Minneapolis and St. Paul. According to one Minneapolis-based insurance company, rate increases for indemnity health plans on average are up approximately 25% to 30% in the Twin Cities area compared to HMO plan average rate increases of 12% to 15%.

Recent comparisons between HMO and the General Mills medical insurance plan indicate that the HMO plans have a substantially lower hospital utilization rate. The Med Center Health Plan, the first HMO offered by General Mills, has a record of 400 days of hospital confinement per 1000 people. The Nicolett Plan confinement rate ranges from 500 to 625 hospital days per 1000 people, not as favorable primarily because of its relatively small membership

(less than 1000), therefore the percentage rate is more susceptible to fluctuation. The hospital utilization rate is expected to level off as the membership increases. In sharp contrast to the HMO plans, the General Mills medical insurance plan hospital utilization rate has been approximately 780 hospital days per 1000 people. Daily hospital rates in the Minneapolis area range from \$115.00 for obstetrical procedures through \$150.00 for surgical procedures to \$290.00 for intensive care.

General Mills has been pleased with its experience in offering the HMO option for a number of reasons, including:

The HMO option is perceived by our employees and their families as an important part of the Company's overall employee benefit package

The HMO option provides our employees with a choice between Company indemnity plan and HMO plan benefits and a choice between fee-for-service and prepaid group practice health care delivery systems.

The prepaid group practice HMO option provides our employees with a central source of quality comprehensive health care and services on a 24-hour basis.

The HMO plan provides a readily available source of professional health care for our Company employees who are transferred to Minneapolis from other parts of the country; there are no problems in finding a new doctor, and

Plan members' medical costs are reasonably well defined and budgeted in advance of any necessary care that they receive under the plan during the course of the year.

In summary, General Mills is pleased with the HMO option. Our satisfaction is based on the quality of care rendered, expressed employee satisfaction, and preliminary indications that costs of health care under HMOs may be contained better than under the traditional fee-for-service system. General Mills supports, as does the Chamber, S.1926 and hopes that it does become law, thereby allowing existing and new HMO plans to compete on a more favorable basis with the traditional group health insurance and service organization plans.

Mr. Chairman, I will be happy to answer any questions that there may be with respect to General Mills experience in offering the HMO option to its employees.

1976 COMPARISON OF GENERAL MILLS GROUP HEALTH
INDEMNITY PLAN AND TWO MINNEAPOLIS HMO PLANS

<u>Service</u>	<u>General Mills Indemnity Plan Coverage (Any accredited hospital)</u>	<u>MedCenter Plan Coverage (Methodist Hospital)</u>	<u>Nicollet-Eitel Plan Coverage (Eitel Hospital)</u>
1. In-hospital (semi-private)	100% of first \$2500 in full, then 96%* coverage of remaining eligible coverage	100% for 365 days	100% for 365 days
2. In-hospitalization for dental surgery	Same as above (dental charges not covered)	Not covered	Hospital coverage at Plan Hospital. The dental charges not covered.
3. Surgery*	Scheduled benefits up to \$1800. Any remaining eligible charges are paid at 80%.	100% of all reasonable and customary fees	100% of all reasonable and customary fees
4. Visits to doctor's office	Paid at 80%*	100%	100%
5. Doctor visits in-hospital	Pays \$12.00 per visit	100%	100%
6. Outpatient Lab. & X-ray tests	100% up to \$100 per calendar year. Any remaining charges are paid at 80%*	100%	100%
7. Home Health	80%*	100% of physician's fee. Member pays \$10 for visit by nurse, therapist, etc.	Member pays \$2 per visit including nurse, therapist, etc. \$10 per physician visit.
8. Prescription drugs	Paid at 80%*	Member pays up to \$2.50 per prescription dispensed at HMO pharmacies. Prescriptions are issued in a 30-day supply (90 days for birth control pills) or 100 units whichever is greater.	Member pays up to \$2 per prescription dispensed at HMO pharmacy. Prescriptions are issued in a 34-day supply.

*Assumes \$75 annual per individual deductible has been satisfied.

<u>Service</u>	<u>General Mills Indemnity Plan Coverage (Any accredited hospital)</u>	<u>MedCenter Plan Coverage (Methodist Hospital)</u>	<u>Nicollet-Eitel Plan Coverage (Eitel Hospital)</u>
9. Maternity	Surgical and hospital benefits are paid	Member pays \$200 if pregnancy terminates 6 months or more after conception. (Conception must occur while member is covered by Plan)	Normal delivery or Caesarian section: Member pays \$200 Other termination of pregnancy: Member pays \$100 if hospital confined; nothing if not hospital confined. Pregnancy benefits available if member was covered by either the HMO Plan or G-Plan at conception.
10. Routine annual	Doctor's charges are not covered. Lab and X-ray charges are covered up to \$100 per calendar year.	100% covered except for physical exams needed to obtain employment or insurance.	100% covered except for physical exams needed to obtain employment or insurance.
11. Immunizations	Not covered	100%	100%
12. Eye and Hearing	Not covered for exams done for correction of vision or hearing	100% coverage (including refraction)	100% coverage (\$6 charge for refraction)
13. Out-patient Accident	100% of first \$200 plus scheduled surgical benefits and 80% of balance. Regular benefits if hospital confined.	80% of first \$2,500 of expenses and 100% in excess, up to \$25,000 per illness.	100% up to \$250 if not hospital-confined. Physician services covered for reasonable charges and hospital for 365 days if hospital confined.
14. Emergency Maternity services received outside Plan facilities	Same as shown in "Maternity Section"	Patient pays first \$200 Plan pays 80% of the balance to \$2500 then 100% to \$25,000	100% up to \$500
15. Ambulance	Included under "in-hospital" benefit - See 1	80%	100% when ordered by a Plan physician in service area; otherwise 100% up to \$25.

*Assumes \$75 annual per individual deductible has been satisfied.

<u>Service</u>	<u>General Mills Indemnity Plan Coverage (Any accredited hospital)</u>	<u>MedCenter Plan Coverage (Methodist Hospital)</u>	<u>Nicollet-Eitel Plan Coverage (Eitel Hospital)</u>
16. Prosthetics	80%*	80%	100% for artificial limbs (braces, crutches, etc. not covered)
17. Private duty Nursing	80%	80%	100% when ordered by a Plan physician while hospital confined. Otherwise treated under home health services.
18. Dental - limited to dental care for accidental injury to the natural teeth	100% of the first \$200 plus 80% of the balance*	80%	80%
19. Mental Health services - outpatient	80% of eligible charges to \$10,000 lifetime maximum.*	No charge for the initial psychiatry evaluation. A company payment of \$5 per person per visit for the first 5 visits; \$10 per visit thereafter to a maximum of 45 visits annually.	Individual, family and marital counseling; member pays \$2 per session for first 5 visits per calendar year; \$15 per visit for next 10 visits, and \$25 per visit for remainder of calendar year.
20. Out-patient chemical dependency	Same as above	Same as above	Same as above
21. Mental Health Services - While hospital-confined	The same as any other illness (See 1)	\$15 per day the first 21 days; and \$25 per day the 22nd to 60th day	Member pays \$20 per day (\$10 per half day) up to 30 days coverage per disability or 60 half days.
22. Counseling	Paid at 80%* if prescribed by a doctor	Five free sessions annually	Subscriber pays \$2 per session for first 5 visits per calendar year; \$15 per visit for next 10 visits then \$25 per visit for remainder of calendar year.
23. Chemical Dependency while hospital confined	The same as any other illness (See 1)	First 15 days at \$15; \$25 per day the 22nd to 73rd day	Residency treatment programs covered in full when arranged by HMO plan physician.

*Assumes \$75 annual per individual deductible has been satisfied.

<u>Service</u>	<u>General Mills Indemnity Plan Coverage (Any accredited hospital)</u>	<u>MedCenter Plan Coverage (Methodist Hospital)</u>	<u>Nicollet-Eitel Plan Coverage (Eitel Hospital)</u>
24. Out of area and Emergency Health Care	Regular benefits good anywhere at all times	80% of first \$2500 100% thereafter to \$25,000 maximum benefit	100% of the first \$250 if not hospital confined and 100% up to \$50,000 if hospital confined.
25. Cosmetic or Plastic Surgery	Not covered unless due to an accident or unless a congenital malformation. Condition must have occurred while insured under the Plan.	Not covered if condition necessitating this treatment occurred prior to coverage under the Plan.	Covered if required due to an accident, which occurred while covered by Plan, but not covered otherwise.
26. Therapy	80%*	100%	100%
27. Congenital Malformations or Anomalies	Benefits the same as any other Condition (See 25)	Covered if member completes a 4-month period (ending on or after effective date of Plan coverage) Without receiving treatment (including drugs or charges for the condition)	Covered the same as any other condition.
28. Services not recommended by a Plan doctor	Reasonable charges by any licensed physician or chiropractor are eligible	Not covered except in emergencies	Not covered except in emergencies

*Assumes \$75 annual per individual deductible has been satisfied.

ELIGIBLE DEPENDENTS

	<u>G-Plan</u>	<u>HMO</u>
Spouse	Yes	Yes
Unmarried dependent children (step, foster or adopted)	to age 22	to age 19
Dependent children who are full-time students	as long as full-time	to age 25
Disabled (mentally or physically) dependent children	as long as dependent	as long as dependent
Dependent parents (step parents or in-laws)	Yes	Yes

Senator NELSON. I am going to go over and vote, and I will come right back.

[Short recess.]

Senator NELSON. Our next presentation will be by the consensus group.

There are eight witnesses listed here. Would those who are present come to the witness table?

I wonder if you gentlemen would identify yourselves and whom you are representing, if you are representing some organization other than yourself, so that the reporter will have an accurate record of who is present. And whenever you make any contribution to the testimony, he will be able to accurately attribute it.

Would you identify yourself, starting on the far left?

STATEMENT OF WALTER McCLURE, PH. D., DIRECTOR, HEALTH POLICY AND PLANNING GROUP, INTERSTUDY, ACCOMPANIED BY JAMES A. LANE, ESQ., COUNSEL, KAISER FOUNDATION HEALTH PLANS; THOMAS O. PYLE, EXECUTIVE VICE PRESIDENT, HARVARD COMMUNITY HEALTH PLAN; HARRY STAMEY, M.D., CHAIRMAN, PREPAYMENT COMMITTEE, AMERICAN GROUP PRACTICE ASSOCIATION, ACCOMPANIED BY LARRY HOFFHEIMER, ESQ., COUNSEL, AMERICAN GROUP PRACTICE ASSOCIATION; STEVEN EPSTEIN, ESQ., WASHINGTON COUNSEL, AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE, ACCOMPANIED BY JAMES BRYAN, WASHINGTON REPRESENTATIVE, AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE; RICHARD H. HOFFMAN, VICE PRESIDENT AND ACTUARY, EQUITABLE LIFE ASSURANCE, ACCOMPANIED BY EDWARD DOLINSKY, DIRECTOR, HEALTH CARE INSURANCE, METROPOLITAN LIFE INSURANCE, AND ARTHUR WOOD, ASSOCIATE DIRECTOR, HEALTH CARE PROGRAM, GROUP INSURANCE DEPARTMENT, PRUDENTIAL INSURANCE; MICHAEL E. HENRY, SENIOR DIRECTOR, ALTERNATE DELIVERY SYSTEMS, BLUE CROSS ASSOCIATION, ACCOMPANIED BY W. PALMER DEARING, M.D., MEDICAL CONSULTANT, BLUE CROSS ASSOCIATION; JAMES ANDERSON, ESQ., COUNSEL, CONNECTICUT GENERAL LIFE INSURANCE CO., ACCOMPANIED BY TED LUTINS, ASSISTANT DIRECTOR, HEALTH INSURANCE ASSOCIATION OF AMERICA, A CONSENSUS GROUP

Mr. HENRY. Michael Henry, Blue Cross Association.

Mr. EPSTEIN. Steven Epstein, counsel to American Association of Foundations for Medical Care.

Mr. ANDERSON. James Anderson, counsel to Connecticut General Life Insurance Co., representing the Health Insurance Association of America.

Mr. HOFFMAN. Richard Hoffman, Equitable Life Assurance, also representing Health Insurance Association of America.

Mr. McCLURE. Walter McClure, InterStudy.

Mr. STAMEY. Harry Stamey from American Group Practice Association.

Mr. LANE. James A. Lane, Kaiser Foundation Health Plans, representing Group Health Association.

Mr. PYLE. Thomas Pyle from Harvard Community Health Plan, also representing Group Health Association of America.

Senator NELSON. That is Kaiser-Permanente?

Mr. LANE. Yes, sir.

Senator NELSON. Do each of you have statements?

Mr. McCLURE. I am a member of the group and I will serve as moderator.

We wish to present our testimony jointly. We are a very diverse group which represents most of the major private organizations interested in stimulating HMO's, and we want to testify jointly as an expression of the unanimity of our views.

If you are agreeable, we will present our testimony in order.

We have asked our members to make their testimony on each issue very brief. Then we would entertain questions as a panel.

Senator NELSON. All right.

All statements will be printed in full in the record.

Mr. McCLURE. We have written statements. These are summary remarks.

Senator NELSON. All right.

Mr. McCLURE. Mr. Chairman, we are very grateful to Senator Kennedy for calling hearings on this urgently needed legislation. We are very grateful to Senator Schweiker, Senator Mondale, and Senator Javits for introducing S. 1926.

We are testifying in favor of this legislation.

We also wish to acknowledge and express our appreciation to Senator Kennedy who was one of the first to exert leadership to stimulate HMO's.

As you know, Senator Kennedy's approach to the original HMO act was a very comprehensive one, while the House version was a more limited demonstration approach. The House-Senate compromise, while retaining comprehensive requirements, deleted the trust fund and subsidies which Senator Kennedy recognized as necessary to support these requirements.

S. 1926 carries forward the intent of the HMO act to encourage quality HMO's, not just demonstrations, while bringing the requirements more into line with the realities of the means available, which now is really the means that consumers are able to afford on their own.

So we are asking your help to get this HMO movement moving again.

May I explain the manner of our presentation?

We have prepared testimony on eight issues, and we will call on each member in turn to present his testimony on that issue.

We have asked them to limit themselves to 3 minutes or less.

First speaking on the benefit package, both the basic and supplemental packages, will be Mr. James Lane of Kaiser-Permanente.

Mr. LANE. Mr. Chairman and members of the committee, we appreciate the opportunity to appear before the committee and present testimony in favor of S. 1926.

A basic purpose of the Health Maintenance Organization Act of 1973 is to encourage the development and expansion of organized health care systems which provide or arrange for health care services on a prepaid basis so that more Americans will have the choice of receiving their health care through such organizations. The act's requirements relating to basic and supplemental health services will frustrate this objective and should be modified.

Sections 2 and 5 of S. 1926 are proposed amendments to the HMO act relating to requirements for basic and supplemental health services. They are intended to accomplish two objectives:

First, provide HMO's flexibility in health benefits design which will increase their ability to provide prepaid plans at a cost which is within the purchasing power of the maximum number of groups and persons. This is a very important objective because one of the problems of the act is that it contains benefits which will price the HMO benefit package beyond the means of certain individuals and groups.

And, second, maintain the essential characteristic of HMO's as prepaid organizations.

The act requires an HMO to provide all its members with basic health services on a prepaid basis, and only allows limited copayments. The required services are comprehensive and must be provided without time limitations except those specified in the act. This means that they will cost more than many competing health benefits plans.

Many persons do not have the financial resources, either through their own income or through contributions by their employers to afford the comprehensive health care services and other features required by the act. These persons will not have an effective choice between conventional health benefits plans and HMO's.

For example, the Kaiser-Permanente medical care program makes available to groups a number of plans, each with a different level of benefits. Approximately 30 percent of the members in our northern California region, 360,000 persons, have chosen plans which are less costly than the basic health services required by the HMO Act. We have estimated that the cost of providing the basic health services required by the act will increase the rates for these plans by as much as 10 percent in northern California.

Senator NELSON. The basic plan required by statute would increase the cost of your lowest option plan by 10 percent, is that what you are saying?

Mr. LANE. That is correct. It will increase the cost of some of our other plans, but not by 10 percent, because they have a higher base, so it is a different percentage.

This increase, together with increases resulting from other provisions of the act, will make the cost of membership in our program prohibitive to a number of individual members and groups, and will force them to drop their membership in our program. We feel that Congress did not intend the act to force some members of existing HMO's to discontinue their membership.

A similar situation will exist for new HMO's. The higher the cost of required basic health services, the smaller the percentage of persons who can afford them. Thus, the new HMO will have an artificially created limit to its growth and is likely to experience serious difficulty in becoming economically viable.

I would like to emphasize that point here. The competition in which we engage with health care insurance organizations, Blue Cross and Blue Shield, is based primarily on the different benefits we provide and the cost of those benefits to the individual. When the individual in an employment situation makes a choice, he looks at the benefits and at the cost, and he needs to see something substantially different from what he is offered in the conventional insurance program, because he is choosing to switch from the conventional to an HMO.

So, an HMO has to be better and less expensive. The more mandated benefits required, the more difficult it is to achieve that objective.

We support the proposed amendments in section 5 of S. 1926 which would help to solve this problem by shifting certain services from the basic health services category into the supplemental health services category.

The HMO Act requires that each supplemental health service must be provided to each member who contracts for such service. Read literally, this requirement would create an administrative nightmare and would make this portion of the act impossible to implement. The Department of Health, Education, and Welfare has recognized this problem and has attempted to ameliorate it by providing, in recently adopted regulations, that selection of supplemental services may be made by group representatives. However, the problem of selection by individual members has not been resolved by the proposed regulations.

If prepaid supplemental health services may be individually selected by members, substantial adverse selection will result. Since the act requires prepaid supplemental health services to be community rated, adverse selection would result in rates for such services that are too high to be competitive with other health benefits plans.

If these supplemental health services cannot be provided on a prepaid basis because of the adverse selection problem, HMO's will be forced to provide such services on a fee-for-service basis contrary to the basic principles underlying the HMO concept.

The supplemental health services requirements should be modified as proposed in section 2 of S. 1926 to make the offering of supplemental health services optional.

In conclusion, the amendments in sections 2 and 5 will provide HMO's with more flexibility than they have under the act. They will not provide the optimum flexibility needed to make the option of HMO membership available to the maximum number of Americans, but they represent a reasonable compromise with the existing requirements.

Therefore, we feel that they constitute a major improvement and, with the other amendments contained in S. 1926, will increase the likelihood of achieving the objectives of the HMO Act of 1973.

Thank you.

[The prepared statement of Mr. Lane follows:]

STATEMENT BEFORE THE SUBCOMMITTEE ON HEALTH
OF THE
LABOR AND PUBLIC WELFARE COMMITTEE
UNITED STATES SENATE
REGARDING S. 1926

Presented by Kaiser Foundation Health Plan, Inc.

December 12, 1975

Mr. Chairman and Members of the Committee. I am James A. Lane, Counsel for Kaiser Foundation Health Plan. We appreciate the opportunity to appear before the Committee and present testimony in favor of S. 1926.

A basic purpose of the Health Maintenance Organization Act of 1973 is to encourage the development and expansion of organized health care systems which provide or arrange for health care services on a prepaid basis so that more Americans will have the choice of receiving their health care through such organizations. The Act's requirements relating to basic and supplemental health services will frustrate this objective and should be modified.

Sections 2 and 5 of S. 1926 are proposed amendments to the HMO Act relating to requirements for basic and supplemental health services. They are intended to accomplish two objectives:

- (1) Provide HMOs flexibility in health benefits design which will increase their ability to provide prepaid plans at a cost which is within the purchasing power of the maximum number of groups and persons; and
- (2) Maintain the essential characteristic of HMOs as prepaid organizations.

Basic Health Services

The Act requires an HMO to provide all its members with basic health services on a prepaid basis, and only allows limited copayments. The required services are comprehensive and must be provided without time limitations except those specified in the Act. This means that they will cost more than many competing health benefits plans. Many persons do not have the financial resources, either through their own income or through contributions by their employers to afford the comprehensive health care services and other features required by the Act. These persons will not have an effective choice between conventional health benefits plans and HMOs.

For example, the Kaiser-Permanente Medical Care Program makes available to groups a number of plans, each with a different level of benefits. Approximately 30 percent of the members in our Northern California Region, 360,000 persons, have chosen plans which are less costly than the basic health services required by the HMO Act. We have estimated that the cost of providing the basic health services required by the Act will increase the rates for these plans by as much as ten percent in Northern California. This increase, together with increases resulting from other provisions of the Act, will make the cost of membership in our Program prohibitive to a number of individual members and groups and will force them to drop their membership in our Program. We feel that Congress did not intend the Act to force some members of existing HMOs to discontinue their membership.

A similar situation will exist for new HMOs. The higher the cost of required basic health services, the smaller the percentage of persons who

can afford them. Thus, the new HMO will have an artificially created limit to its growth and is likely to experience serious difficulty in becoming economically viable.

We support the proposed amendments in Section 5 of S. 1926 which would help to solve this problem by shifting certain services from the basic health services category into the supplemental health services category.

Supplemental Health Services

The HMO Act requires that each supplemental health service must be provided to each member who contracts for such service. Read literally, this requirement would create an administrative nightmare and would make this portion of the Act impossible to implement. The Department of Health, Education and Welfare has recognized this problem and has attempted to ameliorate it by providing, in recently adopted regulations, that selection of supplemental services may be made by group representatives. However, the problem of selection by individual members has not been resolved by the proposed regulations.

If prepaid supplemental health services may be individually selected by members, substantial adverse selection will result. Since the Act requires prepaid supplemental health services to be community rated, adverse selection would result in rates for such services that are too high to be competitive with other health benefits plans.

If these supplemental health services cannot be provided on a prepaid basis because of the adverse selection problem, HMOs will be forced to provide such services on a fee-for-service basis contrary to the basic principles underlying the HMO concept.

The supplemental health services requirements should be modified as proposed in Section 2 of S. 1926 to make the offering of supplemental health services optional.

Conclusion

The amendments in Sections 2 and 5 will provide HMOs with more flexibility than they have under the Act. They will not provide the optimum flexibility needed to make the option of HMO membership available to the maximum number of Americans, but they represent a reasonable compromise with the existing requirements. Therefore, we feel that they constitute a major improvement and, with the other amendments contained in S. 1926, will increase the likelihood of achieving the objectives of the HMO Act of 1973.

[Senator Kennedy assumed the Chair.]

Senator KENNEDY [presiding]. Thank you very much.

I apologize for being late. We had floor action on some very important matters. I hope you will excuse me.

Can you tell me what the differences are going to be in the cost in the benefit package if we follow your recommendation.

Mr. LANE. We have estimated in northern California the difference will be between \$1.50 and \$2 per family per month.

Senator KENNEDY. This is with the changes that you have suggested?

Mr. LANE. Yes.

Senator KENNEDY. It is the elimination of the health service program?

Mr. LANE. Yes.

Senator KENNEDY. And preventive dental care?

Mr. LANE. Alcoholism and drugs.

Senator KENNEDY. And you add the annual physical, is that right?

Mr. LANE. Those are not new cost items to us.

Senator KENNEDY. What is the difference, if you eliminate the annual physician?

Mr. LANE. It does not add anything. We have that as a benefit now. All added benefits are included in the program now.

Senator KENNEDY. All right; \$1.50 a month?

Mr. LANE. Between \$1.50 and \$2.

Senator KENNEDY. Can you give us a breakdown on how you reach that—not now—just submit it for the record?

Mr. LANE. Yes, I will.

Mr. McCCLURE. Mr. Chairman, I would like to emphasize that Mr. Lane's views are the views of this entire Consensus Group, and I would like to also mention that Mr. Lane and Mr. Pyle also represent Group Health Association of America, which is also a member of this Consensus Group.

While organized labor is not an official member of this Group, it has participated in our meetings, and we have worked with them quite closely in an unofficial capacity. Our views and those of the AFL-CIO are in complete agreement with the one exception of how best to amend the 51-percent rule.

I think it is notable that so many organizations as diverse as organized labor and the organizations represented in this Consensus Group should be in such total agreement.

Senator NELSON. Could I ask a question?

You said the AFL-CIO agrees with you.

Are you talking about the National AFL-CIO?

Mr. McCCLURE. Yes. The testimony presented by Mr. Seidman.

There is only one difference in their position and ours and that is on the best way to amend the 51-percent rule.

Mr. Thomas Pyle will present our views on open enrollment.

Mr. PYLE. I am happy to have this opportunity to appear before you and other members of this committee.

I speak from the perspective of Harvard Community Health Plan HMO in Greater Boston, which is 6 years old, has 54,000 members enrolled through 1,800 employer groups, under contract with the welfare department and on nongroup basis.

We also have 1,000 openly enrolled members under a program of health cost supplementation funded by an HEW grant.

So we do have some experience with this topic.

A fly has legs. A table has legs. Therefore, a fly is a table. I am sure you are all familiar with this type of fallacious syllogism. It is most often committed by students and others with no real exposure to the organisms about which they are reasoning.

Similarly, some would reason that if *A* is good and *B* is good, then *A* plus *B* will be better. We see this fallacy in the linking of open enrollment and HMO's.

Access to financial coverage of health care for all Americans is an important and desirable goal. The Consensus Group strongly supports the concept. But this cannot be achieved through the mechanism of HMO's alone; it is a broad issue of social equity, and must be dealt with in a much broader legislative framework.

Let me present what could have been an analogous situation. Imagine the year as 1960, and the Congress, with singular foresight, sets two major goals:

1. That the country shall emphasize small cars because of the fuel crisis which will occur in about a decade.
2. That there should be an emphasis on major pollution and safety devices for automobiles, items of major expense.

These two goals would have been quite reasonable. But, now imagine that the means of achieving these goals is by providing a \$300 million subsidy for small car manufacturers—less than a third of which gets funded—and passing a law which requires small cars, and small cars alone, to have about \$500 worth of pollution and safety equipment—two valuable goals, seriously weakened by combining them. No one who seriously and sincerely supported these two goals would have made this linkage.

It is very important that we keep goals in mind. If our goal is to correct antisocial behavior of the health insurance industry, let us pass legislation about health insurance.

If our goal is to set higher standards, let them apply to everyone.

I am assuming that the principal objective of the HMO bill is to create sound health HMO's in reasonable abundance, enabling more Americans to have a "dual choice." Others may have a different agenda for this legislation. Some would, assuredly, try to use it to destroy this alternative to the prevalent delivery system.

It should be noted that their task might not be too difficult, since HMO's exist in a tough competitive environment, are hard to get started and, by any generally accepted business standard, are woefully undercapitalized.

Others, I am sure, see the HMO as merely one pawn in the strategy to develop national health insurance. Those of us who have our sweat and tears, if not our blood, in HMO's do not wish to seem them as an expendable casualty in the great thrust toward national health insurance.

Again, we in the Consensus Group, including the Group Health Association of America, believe that all Americans should have adequate protection from the financial disaster which an unforeseen major health crises can cause.

The existing law tries to solve this problem by making it the responsibility of a small and frail segment of the health financing industry. Less than 5 percent of the U.S. population is enrolled in HMO's. This small group is unable to underwrite the medical-financial disasters of 100 percent of the population.

New HMO's, which the act purports to encourage, will have more financial difficulties than typical new businesses which, as you know, have a 50-percent failure rate in each of the first 10 years. We believe that the existing legislation may result in an increase in the HMO premiums so that HMO's will become economically attractive to only the very sick, who have no other place to go, who will come in no matter how high the rates, and the very rich.

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However, universal open enrollment permits an individual to avoid the cost of health coverage, and then sign up if and when a health problem is found.

Recently, we heard of a young man who elected to be uninsured when he lost family coverage at age 19. He voluntarily gave up insurance. He avoided paying premiums and saved the money his peers were paying out. Then he had an accident.

Under the existing law, if implemented, someone could come to our office on his behalf, sign him up, pay \$30 a month, and obligate the membership of our organization to some \$13,000 of his hospital costs.

Do we have data on this extra expense? Not much more than we have data on survival rates of people who have driven airplanes into glaciers, since few people have elected to do that. However, since there has been an air of experimentation in consumer conscious group health movements for many years, there is some data.

The Community Health Care Center plan in New Haven, Conn., allowed elective membership, or open enrollment, through a consumers cooperative. Despite a 6-month waiting period for membership, the ambulatory utilization rate was 145 percent that of their regular members, and the hospital utilization was almost five times as high.

At that same plan, conversions from group membership to non-group membership; that is, people who elected to continue coverage when they left their job, had an ambulatory utilization rate one and a half times, and a hospitalization rate of almost three times, those for all members of the plan.

Similar data is found in other situations.

The Arizona health plan in Phoenix, Ariz., among group conversions had a 56 percent higher visit rate. North Care, in Evanston, Ill., conducted an open enrollment period immediately after beginning operations. The per capita cost of those enrollees is 37 percent higher than the average in the plan. The Marshfield Medical Foundation, Marshfield, Wis., openly enrolled individual members and found a

per capita cost which was 37½ percent higher than the average of all their members. That is presenting numbers in a slightly different way than I have seen in their testimony.

Senator KENNEDY. What is the source of your figures?

Mr. PYLE. The source of mine is analysis that was done by a well-recognized actuary named Gordon Trapnell. He did an analysis of that program and he reports that the cost was 37½ percent higher.

Mr. McCURE. He was the former chief actuary from medicare.

Senator KENNEDY. He works for HEW then?

Mr. HOFFMAN. The study was done at the request of HEW.

Senator NELSON. Thirty-seven and a half percent higher than what?

Mr. PYLE. Than the other members, the per capita cost.

Senator NELSON. The other members of that?

Mr. PYLE. Marshfield plan. All of these are compared to other members in that same plan.

It is openly enrolled compared to average in membership.

Senator NELSON. Start that over again. I missed something. I do not understand what you are saying.

Mr. PYLE. In each one of these comparisons I am giving percentage higher cost, when compared to the average for all members in that HMO.

So, in New Haven, as compared to costs of the members, the average of all members in New Haven, what I am talking about is cost to all members of Marshfield community health plan.

In the Marshfield situation, let me read this specific quote on that, the average cost per capita of the nongroup members have been 37½ percent higher than that of the group members.

Senator NELSON. You are saying that in the Marshfield HMO, the individual members have a cost for equivalent coverage 37½ percent higher than the cost of the group members of the HMO?

Mr. PYLE. No, I do not say cost to individuals. I say cost to provide them with health care was 37½ percent higher.

Marshfield, as I understand it, community rates, so the charge to the members is the same. But the cost to the plan of providing care is 37½ percent higher.

Senator NELSON. Who was paying that cost?

Mr. PYLE. The other members are, sir. It is subsidized by the other members.

Senator NELSON. So that you are saying, in effect, that the group members of the Marshfield HMO are paying for the additional cost of health care for the individual members, along with the individuals, who are sharing the costs, sharing the increased cost of the individuals; is that what you are saying?

Mr. PYLE. That is what happens under the community rating system. I think the distinction here is important.

In a typical insurance plan, there would be apt to be, in most parts of the country, experience rating so each group is put together separately for purposes of determining the premium, and there would be a prohibition on this type of open enrollment, so what is happening in the HMO is that you have higher risk people coming in who cannot get into any other financing facility, and they run up the cost which runs the premium up because it gets spread among all the other

people coming in, who have the option of going into some other financing facility where they will not be burdened with this cost.

Mr. HOFFMAN. May I say here that Marshfield people say that as a result of this everyone is paying a dollar more per month per person than they otherwise would in the absence of open enrollment. That means a family which is normally an average of four people or so was paying \$4 a month more than they otherwise would in a plan that did not have this open enrollment feature.

Senator NELSON. You are saying the open enrollment provision of that plan costs all members \$1 per capita more?

Mr. HOFFMAN. In a family \$4.

Mr. McCLURE. It is approximately a 5-percent increase.

Senator KENNEDY. Would the Senator yield on this point?

Senator NELSON. Yes.

Senator KENNEDY. How competitive is that with the rates that are being charged by the commercial?

Mr. McCLURE. Marshfield plan is very unique situation, Senator.

Senator KENNEDY. That is not what I am asking.

Just answer the question about the comparison with commercial.

Mr. HOFFMAN. Competitive situation varies throughout the country as between HMO and what the average type benefit plan might be in various parts of the country.

I would say on an average——

Senator KENNEDY. You are using statistics. I am asking a specific question, is that competitive with the commercials?

Mr. PYLE. I do not have the answer to your question so I cannot respond to it.

Senator NELSON. Pardon me?

Mr. PYLE. I said I did not have an answer of what the competitive premium is in Marshfield. I only have data about what the cost is in Marshfield HMO.

Senator NELSON. I am puzzled on this study to which you made reference.

The study says that the group members are sharing increased costs of the individual members and that sharing results in \$1 more premium per month for each individual in the HMO right?

Mr. PYLE. Yes.

Senator NELSON. If they were individuals, they would be paying several dollars more.

In other words, it is a dollar sharing and that cost sharing is a dollar for everybody per month more; is that correct?

Mr. PYLE. That, I believe, is in the Marshfield testimony. I do not have that dollar figure. I think that question is best answered by the gentleman from Marshfield.

Senator NELSON. I see.

You were using the 37 percent figure?

Mr. PYLE. I have a study which shows 37½ percent higher cost within the Marshfield plan for the people who are openly enrolled, nongroup members, compared with group members.

I do not have extensive data about general costs of health insurance in Marshfield.

I think the other witnesses are a much better source of information on that.

Senator NELSON. It would be helpful for the record if you gentlemen who have a whole lot of expertise would submit for the record what the costs would be to Kaiser-Permanente, or any of the other HMO groups, or private groups, what the cost would be for the same services provided at the Marshfield Clinic so that we could compare, which I think would be important. It is not really important that it costs \$1 more for the Marshfield group, so much as what that service that they get in Marshfield costs compared to the equivalent medical service care by private insurers, by HMO's elsewhere. That would be very helpful in the record.

Mr. PYLE. I do not think that is the issue, sir, with respect to open enrollment.

There would be wide variances in cost around the country. When we are looking at an issue of open enrollment, the relevant factor is what does it do to the cost of a particular HMO. That is what all of these numbers are in terms of what openly enrolled people cost versus other members of HMO.

There would be large differences between Kaiser and Marshfield.

Marshfield, as you know, is a very unique situation, just as everyone of these HMO's is rather unique situation.

Senator NELSON. I understand that. I understand there will be variances in costs, but we are also talking about the method of delivering these services: the costs of services if they are an individual fee for service; the cost of HMO which does not have open enrollment, total cost; cost of one that has closed enrollment. I just think it would be valuable for the record at least to know what the comparative costs are for the same service of other private insurance companies and HMO's versus Marshfield Clinic. I recognize that you are going to have to take into consideration that cost factors are different in different parts of the country, and the cost of living is different in different parts of the country.

But if we are going to look at the whole thing, it would be helpful to see what it does cost to deliver an equivalent service for medical care in various parts of the country.

Mr. McCLURE. Senator, that is a very hard question to even put into terms, because the price of a service is only one part of the expense. It is the quantity of services and the mix of services that is provided in response to illness.

The thing that is of relevance here is not the price of the service. We learned under price controls that you could control the price of services very well, but total expenditures for medical care in the country rose at the same time.

The experience we have now, the best estimates we have now, is that if you take any particular plan's coverage that does not have open enrollment, and you add an open enrolled group, that group will run from somewhere from 50 to 100 percent more than the cost of a group enrollment, of a nonopen enrollment.

So, for each member you add, you add somewhere between 50 and 100 percent additional cost for that particular member.

Senator KENNEDY. If the Senator would yield, as I understand the issue, it is whether with the additional cost they can be competitive?

Mr. McCLURE. That is correct.

Senator KENNEDY. If it is not competitive, restrictive, then it presents an undue burden. You are making the case that you felt it would make it uncompetitive.

Mr. McCLORE. That is correct.

Mr. LANE. I would like to add a point here, an illustration, to give you an example of the problem we are faced with.

We compete basically with experience-rated organizations. If a group has very favorable experience, it will have a low rate.

If a group has a very unfavorable experience, with the same benefits, exactly the same benefits, it will have a much higher rate.

When we go into those two situations, we have the same community rate and are going to attract many more members in the group with bad experience than in the group with the good experience.

Open enrollment takes this one step further, and not only will an HMO enroll substantial numbers of members from groups with bad experience, but an HMO will be subjected to the whole community of bad experience. That is what everybody is scared to death of, to be quite honest with you.

Groups such as the culinary workers in northern California, for example, have very bad experience, and we have 85 percent of the members, the health benefits plan which is the alternate choice has very limited benefits compared to ours. That is what open enrollment will do, open the whole community of bad experiences to HMO's.

Senator NELSON. My father practiced medicine in a little town for 50 years. He had open enrollment. Everybody comes. Those who did not pay, he assumed the cost.

Nevertheless, I am asking this question because I think it is important to the specifics in this legislation. As everybody knows, the field of delivery of medical care in the country is in a stage of transition and rapid change. Where we end up or where we ought to end up, I would not claim to know. I do not have a prescription nor would I impose a prescription upon the country. I would not do it because I do not have enough confidence that I know enough about what the best prescription would be or how to deliver the best care and how to avoid bureaucracy and all those questions.

However, we are looking annually, year round, at delivery of medical care, the cost of medical care, of medication, the cost of private insurance, HMO's, open and closed, all aspects of it.

I think, for purposes of this record, for purposes of information and understanding by the public and Congress, that it would be instructive—even recognizing that you cannot compare something in one part of the country exactly with the other because of all kinds of differentials—but it would still be very valuable in trying to make judgments about the kind of direction we ought to go if we could compare programs of delivery of medical care all with the same options, and find out what that would cost the individual who goes to a doctor on a fee-for-service basis versus the cost of an HMO with open enrollment, in various parts of the country. When I say same delivery of services, I am not saying same quality, because that will vary, but at least they are entitled to the same treatment.

What would it cost? I think we ought to have some baseline. The Marshfield Clinic has 5 years' experience with open enrollment, and it happens to be a very large clinic, as clinics go in this country, and

the issue raised this morning that there is a difference, of course, between a small HMO or 10 or 15 or 20 physicians. We recognize that.

What I would like to see is testimony that would tell us what it would cost in all the various systems that we have—private insurance, HMO's, all the rest—to provide the service that the Marshfield Clinic provides in their open enrollment system vis-a-vis others around the country.

Do you gentlemen not have availability of statistics that could supply that?

Mr. McCCLURE. We have a fairly comparable situation on what it costs to serve comparable populations in HMO versus fee-for-services. Is that the kind of data you are seeking?

Senator NELSON. I would like to see it on various levels of service. Since Marshfield is an open enrollment HMO, and has been for some time, I would like to see what it would cost in various parts of the country and with various systems to provide the same medical care that Marshfield does.

Mr. McCCLURE. Same benefit package?

Senator NELSON. Same benefit package.

Mr. McCCLURE. That would vary in every section of the country.

Senator NELSON. I know. I am asking if you gentlemen can supply it for the record.

Mr. LANE. We would be glad to do that.

I would like to work with your staff on some assumptions because we have to make some assumptions. I think you must understand that Marshfield is not Los Angeles, Calif., and if you put a clinic down in Los Angeles, Calif., and have open enrollment, you are going to be surprised at the results compared to Marshfield.

Senator NELSON. I went to college in California—do not tell me anything about California. I was happy to get home. [Laughter.]

We have looked at malpractice insurance. It is an absolutely preposterous situation, and that has to be taken into account. I think it would be valuable, and we do not have it any place in the record, and if you gentlemen could provide it, it would be very helpful.

Mr. HOFFMAN. We would be very happy to try to do that.

Senator NELSON. Work with the staff to get a baseline.

Mr. HOFFMAN. I think it should be made clear that as far as the competitive environment is concerned, the environment in which HMO operates, it is not competing in an environment where the health insurance alternative is providing the same benefits as HMO is offering. Therefore, in most parts of the country, almost every part of the country, the cost of the HMO is higher than the cost of the health insurance program.

Senator NELSON. I would not want just a narrow picture—I would like to work out and have a number of variables compared. I would like to use Marshfield as a baseline for an open enrollment HMO, for example, and whatever other varieties that would be instructive and valuable and educational for us in the Congress who have to try to make intelligent decisions, as difficult as that may be, and as rarely as it occurs.

Mr. HOFFMAN. Again, in terms of the competitive environment, HMO has already got to charge more than the health insurance alter-

native, and that is why the open enrollment, extra open enrollment cost, and the extra cost of higher benefits looms so important.

I would like to point out that in evaluating that extra cost, the consumer, the employee, is not looking at the total premium he must pay, but the extra he must pay in order to join the HMO.

Typically, across the country, that extra averages around \$10 or so. Therefore, every dollar additional cost that the HMO must charge is a 10-percent increase in what he must pay in order to join the HMO.

Taking this Marshfield as an example, if it costs a man with a family \$4 more a month, because of the open enrollment, he is being asked to pay \$14 extra instead of, say, \$10. That is really a 40-percent increase in what he has to pay. This is a very crucial point.

Senator NELSON. Of course, the Marshfield Clinic operates in its own geographic economic environment, and their competition is the competition of those clinics and those solo practitioners and others within that area.

Mr. McCURE. They are the only physicians in their community. They are in a small rural town. The nearest physician is some 20 miles away.

Senator NELSON. You do not have to instruct me on the geography. I understand.

Mr. McCURE. It is not a truly competitive situation, sir. That is perhaps the most unique thing about it.

I think the gentleman from Marshfield can explain that more clearly than we can.

Senator NELSON. I have not looked at any map as to the geography of HMO's up there. I would like to see some of the statistics we talked about placed in the record. I think that is only part of the picture.

I might say, and I am sure you are aware, I have looked at some of the variable statistics on surgical procedures in various parts of the country. I think the public ought to be informed about that, too.

There are some shocking differentials in surgical fees for the same procedures, which fees vary widely from area to area and they are unconscionable.

Mr. McCURE. We feel HMO's can make a strong improvement in this situation.

Senator NELSON. There is a vote.

We will be right back.

[Short recess.]

Senator KENNEDY. Mr. Pyle, would you continue?

Mr. PYLE. Blue Cross/Blue Shield in New Jersey, an indemnity type plan, conducted an open enrollment in 1973. There was a 12-month waiting period before pre-existing conditions were covered. The cost in the first year was 35 to 40 percent higher than the average of all members. After 12 months, it went up to 60 percent above the average.

In 1960, the Health Insurance Plan of New York, in New York City, conducted an enrollment which, while ruling out people with such diseases as cancer and tuberculosis, was essentially an open enrollment. The enrollees were significantly older than the average HIP membership; they had a 70-percent greater physician utilization rate in early years.

More recently, this has come down to a 40-percent physician utilization rate and a 30-percent higher hospitalization rate. Screening these

initial members would have kept about 40 percent of them from joining, using the traditional criteria applied in issuing health insurance.

It should be noted that the HIP utilization figures I have just quoted cover a span of 12 years, from 1960 to 1972. This is a clear indication that heavier utilization is not purely a startup phenomenon, as some would argue.

Under a HEW grant to provide health care to the near poor, the Harvard Community Health Plan openly enrolled 1,000 individuals. Their hospitalization was double that of the rest of our members, and the ambulatory utilization rate was 25 percent above. One woman was enrolled by her family while she was in the hospital with a stroke.

Incidentally, just a bit more on the reject rate—the Ross Loos Medical Group in Los Angeles, Calif., in a recent sample of 60 applicants, rejected 15 and accepted 5 with waivers. This gives you some idea of the proportion that would want to come in under an open enrollment.

The Group Health Plan of St. Paul, Minn., does not openly enroll, but it does offer nongroup membership to group conversions. It has had no direct enrollment on a nongroup basis since 1973 because of the higher utilization of this group. To quote their general manager, Maurice J. McKay, with respect to nongroup conversions—

In 1973 these people utilized 25 percent more services per person than those covered under our group contract and in 1974 this percentage had increased to 30 percent. What is more significant is that by and large these nongroup members were at one time members of the Group Health Plan under a group contract. They are consumer oriented, aware that the premium their group paid is partially a function of the services that group requires, and support the philosophy espoused by the Group Health Plan. Yet at the same time they had to make the decision to continue with nongroup coverage or seek an alternative health coverage, they were aware of the probable medical services they would require and were economically motivated to get the most from their dollar by continuing their Group Health Plan. Their rationale is borne out by their statistics on medical service utilization.

Of course, if they did not think they needed medical services, they probably would not have continued paying a premium which was fully out of their own pocket.

Incidentally, it is interesting to note that the Group Health Plan, and most other prepaid group practices, permit conversion to a nongroup policy with a very high level of benefits, without any proof of health status. This is not the custom for most Blue Cross and Indemnity Plans.

Mr. McKay went on to say, "Group Health Plan is firmly opposed to open enrollment for potential members who have no commitment to Group Health Plan." It should be noted that Group Health Plan is a consumer cooperative, and this is a policy of the organization.

There are many potential solutions to the problem of financial protection for all citizens. National health insurance is the most obvious. Another possibility might be a Federal law requiring all financiers of health care to accept all applicants, regardless of health status. We would favor such a law.

Some proposed subsidies. We reject this. Dealing with a bureaucracy to gain this money is another encumbrance on the HMO. Furthermore, we believe it seriously compromises and clouds the issue of HMO success, since the critics will say that we are another subsidized program that cannot stand on its own. Many believe that a subsidy

provision in these amendments would invoke a sure veto. Even if this is incorrect, there is not a good record in funding such provisions, despite the authorizations which are passed.

As Former Assistant Secretary Duval once noted—

The American people are convinced they can accomplish anything and will put up peanuts to try.

Finally, HMO's are marketplace creatures. That is the thing which has distinguished them from the sad mess we have in the rest of the delivery system in America. Let us not make HMO's fat and happy and unresponsive with subsidies.

We have noted with less than pleasure the railroads, the airlines, and other industries which become embroiled with a combination of Government subsidy and regulation. We do not really have a good record in this area.

We do not believe in waivers. There is a lack of criteria; we have no reason to believe they can be administered effectively, the uncertainty which they stimulate puts a scare factor in the whole business of Federal qualification, and none of us knows how to develop the data to substantiate need.

As one plan said in a letter to GHAA, we have no data about the extra cost of open enrollment, and we are reluctant to apply for Federal certification. The whole business of waivers and the basis on which they might be given seem to me to be a crazy contradiction.

We strongly request the amendment of Public Law 93-222 to remove the requirement for open enrollment. I can assure you that most of the organizations in this field will provide open enrollment just as soon as it makes any kind of economic sense, and there is even a good chance that we might do it a bit sooner, judging by our records to date.

We believe that as soon as open enrollment makes any kind of reasonable sense that HMO's will be willing to openly enroll.

If you look at our records to date, a number of us, including my own organization, have openly enrolled. We have seen the results of it. I think we will continue to try and do it and try with increased access to care.

I think it is something most of us are very much committed to.

[The prepared statement of Mr. Pyle follows:]

STATEMENT OF THOMAS O. PYLE, EXECUTIVE VICE PRESIDENT, HARVARD COMMUNITY HEALTH PLAN, BEFORE THE UNITED STATES SENATE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE

Mr. Chairman:

My name is Thomas O. Pyle, and I am the Executive Vice President of the Harvard Community Health Plan. I am pleased to have this opportunity to appear before you and other members of this committee.

A fly has legs. A table has legs. Therefore, a fly is a table. I am sure you are all familiar with this type of fallacious syllogism. It is most often committed by students and others with no real exposure to the organisms about which they are reasoning.

Similarly, some would reason that if A is good and B is good, then A + B will be better. We see this fallacy in the linking of open enrollment and HMOs. Access to financial coverage of health care for all Americans is an important and desirable goal. The Consensus Group strongly supports the concept. But this cannot be achieved through the mechanism of HMOs alone; it is a broad issue of social equity, and must be dealt with in a much broader legislative framework.

Let me present what could have been an analogous situation. Imagine the year as 1960, and the Congress, with singular foresight, sets two major goals.

1. That the country should emphasize small cars, because of the fuel crisis which will occur in about a decade.
2. That there should be an emphasis on major pollution and safety devices for automobiles, items of major expense.

These two goals would have been quite reasonable. But now imagine that the means of achieving these goals is by providing a \$300 million subsidy for small car manufacturers (less than a third of which gets funded) and passing a

law which requires small cars, and small cars alone, to have about \$500.00 worth of pollution and safety equipment -- two valuable goals, seriously weakened by combining them. No one who seriously and sincerely supported these two goals would have made this linkage.

I am assuming that the principal objective of the HMO Bill is to create sound, healthy HMOs in reasonable abundance, enabling more Americans to have a "dual choice". Others may have a different agenda for this legislation. Some would, assuredly, try to use it to destroy this alternative to the prevalent delivery system. It should be noted that their task might not be too difficult, since HMOs exist in a tough competitive environment, are hard to get started, and by any generally accepted business standard, are woefully undercapitalized.

Others, I am sure, see the HMO as merely one pawn in the strategy to develop national health insurance. While the establishment of national health insurance is a laudable goal supported by all of us in the Consensus Coalition, we hope that the purpose of the majority here is to increase the number of viable HMOs. Those of us who have our sweat and tears -if not our blood- in HMOs do not wish to see them as an expendable casualty in the great thrust toward national health insurance.

Again, we in the Consensus Group, including the Group Health Association of America, believe that all Americans should have adequate protection from the financial disaster which an unforeseen major health problem can cause. The existing law tries to solve this problem by making it the responsibility of a small and frail segment of the health financing industry. Less than 5% of the U.S. population is enrolled in HMOs. This small group is unable to underwrite the medical-financial disasters of 100% of the population. New HMOs, which the act purports to encourage, will have more financial difficulties than typical new businesses, which, as you know, have a 50% failure rate in

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Reasonable premiums in any health financing scheme require the distribution of cost which comes from a spread of health status. Normal group coverage, with employer contributions, creates the likelihood of such a balance. For this reason we are able to support "open enrollment" in employer groups, which all of us practice in the employer groups we cover, despite the fact that we get our fair share of high health risks in these situations. However, universal open enrollment permits an individual to avoid the cost of health coverage, and then sign up if and when a health problem is found. Not only do we help the unfortunates of our population, but also the "sharpie" millionaire.

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Do we have data on this extra expense? Not much more than we have data on survival rates of people who have driven airplanes into glaciers, since few people have elected to do that. However, since there has been an air of experimentation in consumer conscious group health movements for many years, there is some data.

The Community Health Care Center Plan in New Haven, Connecticut allowed elective membership, or open enrollment, through a Consumers Cooperative. Despite a six month waiting period for membership, the ambulatory utilization rate was 145% that of their regular members, and the hospital utilization rate was almost 5 times as high. At that same Plan, conversions from group membership to non-group membership, that is, people who elected to continue coverage when they left their job, had an ambulatory utilization rate 1-1/2 times, and a hospitalization rate of almost three times, those for all members of the Plan.

Similar data is found in other situations. The Arizona Health Plan in Phoenix, Arizona, among group conversions had a fifty-six percent higher visit rate. North Care, in Evanston, Illinois, conducted an open enrollment period immediately after beginning operations. The per capita cost of those enrollees is 37% higher than the average in the Plan. The Marshfield Medical Foundation, Marshfield, Wisconsin, openly enrolled individual members, and found a per capita cost which was 37-1/2% higher than the average of all their members. Blue Cross-Blue Shield in New Jersey, an indemnity type plan, conducted an open enrollment in 1973. There was a 12 month waiting period before pre-existing conditions were covered. The cost in the first year was 35 to 40% higher than the average of all members; after 12 months it went up to 60% above the average.

In 1960, the Health Insurance Plan of New York, in New York City, conducted an enrollment which, while ruling out people with such diseases as cancer and tuberculosis, was essentially an open enrollment. The enrollees were significantly older than the average HIP membership; they had a 70% greater physician utilization rate in early years. More recently, this has come down to a 40% higher physician utilization rate and a 30% higher hospitalization rate. Screening these initial members would have kept about 40%

of them from joining, using the traditional criteria applied in issuing health insurance. It should be noted that the H.I.P. utilization figures I have just quoted cover a span of 12 years, from 1960 to 1972. This is a clear indication that heavier utilization is not purely a start-up phenomenon, as some would argue.

Under an HEW Grant to provide health care to the near poor, the Harvard Community Health Plan openly enrolled 1,000 individuals. Their hospitalization was double that of the rest of our members, and the ambulatory utilization rate was 25% above. One woman was enrolled by her family while she was in the hospital with a stroke.

Incidentally, just a bit more on the reject rate - the Ross Loos Medical Group in Los Angeles, California, in a recent sample of 60 applicants, rejected 15 and accepted 5 with waivers. This gives you some idea of the proportion that would want to come in under an open enrollment.

The Group Health Plan of St. Paul, Minnesota does not openly enroll, but it does offer non-group membership to group conversions. It has had no direct enrollment on a non-group basis since 1973 because of the higher utilization of this group. To quote their General Manager, Maurice J. McKay, with respect to non-group conversions; "In 1973 these people utilized 25% more services per person than those covered under our group contract, and in 1974 this percentage had increased to 30%. What is more significant is that by and large these non-group members were at one time members of the Group Health Plan under a group Contract. They are consumer oriented, aware that the premium their group paid is partially a function of the services that group requires, and support the philosophy espoused by Group Health Plan. Yet at the same time they had to make the decision to continue with non-group coverage or seek an alternative health coverage, they were aware of the probable medical services they would require and were economically

motivated to get the most from their dollar by continuing their Group Health Plan. Their rationale is borne out by their statistics on medical service utilization." Of course, if they did not think they needed medical services, they probably would not have continued paying a premium which was fully out of their own pocket. Incidentally, it is interesting to note that the Group Health Plan, and most other prepaid group practices, permit conversion to a non-group policy with a very high level of benefits, without any proof of health status. This is not the custom for most Blue Cross and Indemnity Plans.

Mr. McKay went on to say, "Group Health Plan is firmly opposed to open enrollment for potential members who have no commitment to Group Health Plan." It should be noted that Group Health Plan is a Consumer Cooperative, and this is a policy of the organization.

There are many potential solutions to the problem of financial protection for all citizens. National Health Insurance is the most obvious. Another possibility might be a federal law requiring all financiers of health care to accept all applicants, regardless of health status. We would favor such a law.

Some propose subsidies. We reject this. Dealing with a bureaucracy to gain this money is another encumbrance on the HMO. Furthermore, we believe it seriously compromises and clouds the issue of HMO success, since the critics will say that we are another subsidized program that can't stand on its own. Many believe that a subsidy provision in these amendments would invoke a sure veto. Even if this is incorrect, there is not a good record in funding such provisions, despite the authorizations which are passed. As former Assistant Secretary Duval once noted, "the American people are convinced they can accomplish anything and will put up peanuts to try."

Finally, HMOs are marketplace creatures. That is the thing which has distinguished them from the sad mess we have in the rest of the delivery system in America. Let's not make HMOs fat and happy and unresponsive with subsidies. We've noted with less than pleasure, the railroads, the airlines, and other industries which become embroiled with a combination of government subsidy and regulation. We don't really have a good record in this area.

We do not believe in waivers. There is a lack of criteria, we have no reason to believe they can be administered effectively, the uncertainty which they stimulate puts a scare factor in the whole business of federal qualification and none of us knows how to develop the data to substantiate need. As one Plan said in a letter to GHAA, we have no data about the extra cost of open enrollment, and we are reluctant to apply for federal certification. The whole business of waivers and the basis on which they might be given, seems to me to be a crazy contradiction. We strongly request the amendment of Public Law 93-222 to remove the requirement for open enrollment. I can assure you that most of the organizations in this field will provide open enrollment just as soon as it makes any kind of economic sense, and there is even a good chance that we might do it a bit sooner judging by our records to date.

Mr. McCLURE. Harry Stamey, chairman, prepayment committee of the American Group Practice Association, will speak to the 51-percent rule.

Dr. STAMEY. I am pleased to have the opportunity to speak to you today on behalf of American Group Practice Association.

One important goal of the Health Maintenance Organization Act of 1973 was to foster the growth and development of group practices providing comprehensive health care benefits. This goal, however, has been seriously frustrated by the language in the final bill that defines a medical group as a legal entity whose members "as the principal professional activity and a group responsibility engage in the coordinated practice of their profession for a health maintenance organization."

The latter portion of this definition, for a health maintenance organization, requires the existing fee-for-service group attempting to provide comprehensive prepaid health benefits, regardless of its size or location to convert more than 50 percent of its existing practice to prepayment. Its effect has been to deter a great many of our Nation's finest group practices from delivering comprehensive prepaid health benefits.

Through regulations, the Department of Health, Education, and Welfare has attempted to ameliorate this problem by allowing a 3-year phase-in. However, this still requires that a group commit itself to a goal that may be either (1) clearly impossible, as in that of the large regional referral centers, such as Mayo, Lahey, Cleveland, Ochsner, Scott White, Mason, and Palo Alto clinics and in my own group, the Geisinger Medical Center; or (2) highly impractical, as in most medium and larger sized groups.

In addition, this language requires that a group commit itself to a goal which will be ultimately determined by the people living in the group's community and not by the physicians within the group.

Dr. Bill Roy, former Congressman from Kansas and one of the primary authors of the HMO Act of 1973 felt so strongly about this issue that he introduced an amendment during the last session of Congress to correct this language. In his preamble to the amendment, Dr. Roy states:

I feel strongly that existing fee-for-service group practices offer a great opportunity for the development of HMOs. But to require that these groups convert more than 50 percent of their practice to an HMO is not reasonable.

That portion of the definition that requires physicians in group practices to be "principally engaged in the coordinated practice of their profession" is desirable, and an inherent and essential characteristic of group practices delivery of comprehensive health benefits. But to insist that they commit themselves to a goal that may be impossible or impractical will serve only to deter the reputable and financially sound group practices from participating in the HMO program.

There are some who reason that existing group practices may qualify as HMO's by calling themselves Independent Practice Associations or IPA's. To those not associated with group practice, this may appear to be a simple solution and one of little consequence. But every group practice that exists today has had to overcome a multitude of obstacles and traditions to become a group practice—a group practice that could

offer to the public the convenience and quality of a coordinated and integrated practice.

They are not apt to take lightly to offering themselves to the public as Independent Practice Associations—something they are not. This will be borne out in the administration's testimony before this committee, showing a drastic reduction in the number of provider groups pursuing HMO development since the passage of the act.

More than 2 years ago, when the HMO Act of 1973 was being written, there was some concern whether prepayment and fee-for-service could exist side by side and still provide the highest quality medical care to all patients. This can no longer be considered a serious question.

Too many groups have successfully demonstrated the logic and desirability of utilizing the resources of existing group practices to build HMO's.

Marshfield Clinic in Marshfield, Wis., is now serving 23,500 health plan enrollees; Lovelace Clinic in Albuquerque, N. Mex., has 8,500 enrollees; InterGroup in Chicago, 20,000; Trover Clinic in Madisonville, Ky., has 8,000; and St. Louis Park Medical Center also serves over 8,000 enrollees. These are only a few.

In addition, one cannot forget that many of the HMO's sponsored by insurance carriers, for example, do indeed receive their physician services from groups which are still principally engaged in fee-for-service practice. The evidence is overwhelming. Existing group practices provide a most logical, economical and fertile resource for the development of HMO's.

We should encourage and not discourage such provider involvement. Accordingly, we support the amendment in S. 1926 to redefine the term "medical group" in the Health Maintenance Organization Act of 1973 by deleting the words "for a Health Maintenance Organization."

[The prepared statement of Dr. Stamey follows:]

A STATEMENT ON

S. 1926

HEALTH MAINTENANCE ORGANIZATION

AMENDMENTS OF 1975

By:

HARRY STAMEY, M. D.
MEDICAL DIRECTOR
GEISINGER MEDICAL CENTER

PRESENTED TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

July 14, 1975

Mr. Chairman, I am Doctor Harry Stamey, Medical Director of Geisinger Medical Center in Danville, Pennsylvania and Chairman of the American Group Practice Association's Committee on Prepaid Health Care. I am accompanied by Larry Hoffeuner, Counsel for AGPA. I am pleased to have the opportunity to speak with you today on behalf of the American Group Practice Association, the national professional association of physicians and dentists in group practice.

One important goal of the Health Maintenance Organization Act of 1973 was to foster the growth and development of group practices providing comprehensive health care benefits. This goal, however, has been seriously frustrated by the language in the final bill that defines a medical group as a legal entity whose members "as the principal professional activity and a group responsibility engage in the coordinated practice of their profession for a health maintenance organization". The latter portion of this definition, for a health maintenance organization, requires the existing fee-for-service group attempting to provide comprehensive prepaid health benefits, regardless of its size or location to convert more than 50% of its existing practice to prepayment. Its effect has been to deter a great many of our nation's finest group practices from delivering comprehensive, prepaid health benefits.

Through regulations, the Department of Health, Education and Welfare has attempted to ameliorate this problem by allowing a three year phase-in. However, this still requires that a group commit itself to a goal that may be either: 1) clearly impossible (as in that of the large regional referral centers such as Mayo, Lahey, Cleveland, Ochsner, Scott and White, Mason and Palo Alto clinics and in my own group, the Geisinger Medical Center); or 2) highly impractical (as in most medium and larger sized groups). In addition, this language requires that a group commit itself to a goal which will be ultimately determined by the people living in the group's community and not by the physicians within the group. Doctor Bill Roy, former Congressman from Kansas and one of the primary authors of the HMO Act of 1973 felt so strongly about this issue that he introduced an amendment during the last session of Congress to correct this language. In his preamble to the amendment Doctor Roy states: "I feel strongly that existing fee-for-service group practices offer a great opportunity for the development of HMOs. But to require that these groups convert more than 50% of their practice to an HMO is not reasonable."

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There are some who reason that existing group practices may qualify as HMOs by calling themselves Independent Practice Associations or IPAs. To those not associated with group practice this may appear to be a simple solution and one of little consequence. But every group practice that exists today has had to overcome a multitude of obstacles and traditions to become a group practice -- a group practice that could offer to the public the convenience and quality of a coordinated and integrated practice. They are not apt to take lightly to offering themselves to the public as Independent Practice Associations -- something they are not. This will be borne out in the Administration's testimony before this Committee, showing a drastic reduction in the number of provider groups pursuing HMO development since the passage of the Act.

More than two years ago, when the HMO Act of 1973 was being written, there was some concern whether prepayment and fee-for-service could exist side by side and still provide the highest quality medical care to all patients. This can no longer be considered a serious question. Too many groups have successfully demonstrated the logic and desirability of utilizing the resources of existing group practices to build HMOs. Marshfield Clinic in Marshfield, Wisconsin, is now serving 23,500 Health Plan Enrollees; Lovelace Clinic in Albuquerque, New Mexico has 8,500 enrollees; InterGroup in Chicago, 20,000; Trover Clinic in Madisonville, Kentucky has 8,000; and St. Louis Park Medical Center also serves over 8,000 enrollees. These are only a few.

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Mr. McCLURE. Mr. Steven Epstein, Washington counsel for the American Association of Foundations for Medical Care.

Mr. EPSTEIN. Mr. Chairman, I am Steven Epstein, counsel to the American Association of Foundations for Medical Care.

AAFMC strongly supports all the amendments proposed under S. 1926 as essential to the growth of health maintenance organizations as a viable alternative delivery system in the health marketplace.

In particular, we wish to speak to section 3 of S. 1926. Section 3 is intended to remove an unnecessary barrier in the statute to the qualification of foundations for medical care as individual practice association-type HMO's. Specifically, this amendment would permit both already existing and newly forming foundations for medical care to qualify as individual practice associations under Public Law 93-222, without the presently existing burdensome requirements of forming two not-for-profit corporations, creating two sets of bylaws and other corporate documents, obtaining two separate Federal and State tax-exempt status rulings, hiring two independent staffs, operating two independent claims processing procedures, fabricating various unnecessary contractual arrangements, and operating two corporate structures.

These requirements, in our view, create sufficient complications and confusion to operate as a "chilling factor" for well-intentioned foundation physicians to participate in the Federal HMO program.

Please be assured that this amendment will in no way relieve a foundation from meeting all other substantive requirements of Public Law 93-222, as such act may be amended. Section 3 is intended merely as relief from an oppressive procedural requirement.

Foundations for medical care represent a health care delivery system designed to provide easily accessible, comprehensive, high-quality medical care at minimal cost to the patient and the community. Foundations for medical care provided the model for the individual practice association type of HMO. They have demonstrated that the local medical profession can, by mutual agreement, deliver medical services in an organized mode—not under one roof, as in a group practice HMO—but as a "clinic without walls," through the foundation mechanism.

Through the encouragement of individual practice associations as modified by the proposed amendments of S. 1926, the Federal Government can most effectively assist local medical professional groups in every part of the country to organize responsible locally administered medical care delivery systems, utilizing most efficiently the existing manpower and institutional resources of the community.

Thank you.

[The prepared statement of Mr. Epstein follows:]

STATEMENT

ON
S. 1926

SUBCOMMITTEE ON HEALTH
SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE

December 12, 1975

Steven Epstein, Esq.
Counsel
American Association of Foundations for Medical Care

Mr. Chairman and Members of the Committee, I am Steven Epstein, Counsel to the American Association of Foundations for Medical Care ("AAFMC").

AAFMC strongly supports all the amendments proposed under S. 1926 as essential to the growth of health maintenance organizations ("HMOs") as a viable alternative delivery system in the health marketplace.

In particular, we wish to speak to Section 3 of S. 1926. Section 3 is intended to remove an unnecessary barrier in the statute to the qualification of foundations for medical care as individual practice association type HMOs. Specifically, this amendment would permit both already existing and newly forming foundations for medical care to qualify as individual practice associations under P.L. 93-222 without the presently existing burdensome requirements of forming two not-for-profit corporations, creating two sets of by-laws and other corporate documents, obtaining two separate federal and state tax-exempt status rulings, hiring two independent staffs, operating two independent claims processing procedures, fabricating various unnecessary contractual arrangements, and operating two corporate structures. These requirements, in our view, create sufficient complications and confusion to operate as a "chilling factor" for well-intentioned foundation physicians to participate in the federal HMO program.

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Through the encouragement of individual practice associations as modified by the proposed amendments of S. 1926, the federal government can most effectively assist local medical professional groups in every part of the country to organize responsible locally administered medical care delivery systems, utilizing most efficiently the existing manpower and institutional resources of the community.

Senator KENNEDY. We try in legislation to provide some degree of flexibility when there are important services which are needed, and the only ways and means of providing those is to permit contract and procedures to be followed.

A very important point that has been made in the development of HMO's is in order to try to get some kind of handle on the number of services that are being provided, it is important that HMO's have a more focused posture and position with relationship to the doctors who are working there.

An important point, I think, has been made to the extent that they do not have this kind of focus and attention, that there has been the pattern of perhaps weaker control in the range of services, the amount of services that have been provided, and cost as well.

Would you comment on the issue?

Mr. EPSTEIN. The foundation concept already provides for an organized system of care. A not-for-profit corporation is established which sets up a board of directors and attempts to provide the organized system you are interested in creating.

The technical requirements of Public Law 93-222, as they presently exist, mandate that two separate corporations be created, whereas the foundation movement has found that one is adequate.

Senator KENNEDY. Give me the answer again, please.

Mr. EPSTEIN. The foundation system provides for the creation of a not-for-profit corporation, which acts as the focal point for an organized system of health care.

The board of directors of the foundation establishes appropriate benefit packages and claims processing procedures, makes appropriate contracts with physicians and sets up a mechanism for quality control.

Presently existing requirements of Public Law 93-222 mandate two separate corporations, whereas the foundation experience has shown that one corporation effectively provides an adequate and appropriate structure for a health care system of independent physicians.

Senator KENNEDY. Do you think that is what the amendment accomplishes, or is it somewhat broader than that?

I must say I would like to get another look at it and obviously will.

Would the rest of you be willing to accept that as you define it?

Mr. McCLORE. That is the group's views.

Mr. Chairman, I will speak to community rating. Before discussing community rating, I would like to indicate InterStudy's view that S. 1926 will provide a much more favorable climate for HMO growth. Without these amendments, the HMO movement will tend to flounder.

Regarding community rating, I would like to start with a conclusion.

Putting aside the argument for and against community rating itself, the unilateral imposition of community rating on HMO's alone and not upon traditional systems works an unfair and uncompetitive hardship on HMO's.

My first point is that in the insurance industry, community rating has virtually been driven out by experience rating everywhere there is truly a competitive situation. On the other hand, HMO's are so efficient that in many areas of the country, and with many groups, even with community rating they have been able to successfully compete against experience rating insurance companies. This is not true in all

areas or in all groups, and therefore community rating is a competitive hardship in these areas and with these groups.

My second point is that community rating is a particular hardship on the new and small HMO's. These new HMO's scrambling to get into the market must often start with higher risk groups because there is less competition for them. Then the community rating requirement makes it difficult to add additional groups.

My third point is that community rating works a hardship even on mature HMO's. For a variety of historical and market reasons, most mature HMO's depart, sometimes substantially, from community rating. While very few have purely experienced rated groups, they do have considerable departures.

The requirement of strict community rating in the original HMO Act means these HMO's will have to negotiate increased rates with many of their own member groups. This will work hardship and may cause a loss of some groups from these HMO's.

My fourth point is that community rating is really addressed to a larger social issue; namely, covering the high risk patient. It is not essential to the logic or efficient operation of HMO's themselves.

Therefore, it seems to me unfair and will work a hardship on HMO's, to place this burden unilaterally upon them, whereas it is really a question of national health insurance which the whole country should face rather than just consumers in HMO's.

Therefore, this consensus group supports S. 1926 amendments to phase in community rating at least over 5 years.

[The prepared statement of Mr. McClure, on behalf of InterStudy, follows:]

A STATEMENT ON

S. 1926

HEALTH MAINTENANCE ORGANIZATION
AMENDMENTS OF 1975

By:

INTERSTUDY

Walter McClure, Ph.D.
Director
Health Policy and Planning Group

PRESENTED TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

December 12, 1975

I am Dr. Walter McClure, Ph.D., Associate Director of the Health Policy Group of InterStudy, an independent, non-profit research, policy research, and consulting organization located in Minneapolis, Minnesota. I appreciate very much the opportunity to be here today. My colleagues and I at InterStudy--which include Dr. Paul Ellwood, Dr. Robert Schlenker, Dr. Gary Appel, and others--have been engaged in research and policy analysis in the area of HMOs for over five years, and we have worked with this Committee, other Committees of the Congress, and HEW on HMO and other health care issues. We hope this work has been helpful to you.

InterStudy believes that the Schweiker-Mondale-Javitts bill (S.1926) amending the HMO Act of 1973 (P.L. 93-714) will greatly strengthen that Act and encourage a more fair and favorable climate for HMOs. If we are reading your intent correctly, the HMO Act represented a new approach by the Congress, complementary to your continuing development of health planning and regulation (most recently expressed in P.L. 93-641). The new approach of the HMO Act directly encouraged diverse private efforts to constructively restructure the health care system. Thus, Congress is now pursuing a balanced strategy of fostering public planning on the one hand and private restructuring on the other to get on top of our national problems in the cost, distribution, and quality of health care. If we further read your purpose correctly, it was not the intent of the HMO Act to force new modes of practice on anybody, but rather to remove existing market, legal, financial, and administrative barriers to improved alternative delivery systems, and then see if they would appeal to consumers and providers and grow under such a "fair market test." In the time that the HMO Act has been in effect we have learned that

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some improvements are needed to assure that fair market conditions actually hold. S. 1926 appears to be an essential, realistic and significant step to assuring that HMOs receive a fair market test.

I have been asked to speak today specifically to the issue of community rating. The HMO Act presently requires HMOs to community rate, that is, the premium for all persons (or families of similar composition) in a qualified HMO is required to be the same, independent of their individual medical risk factors and prior cost experience or the risk factors and experience of the subscriber group with whom they are enrolled. I would like to start with a general conclusion about community rating, make four points in support of this conclusion, and close with some recommendations.

My general conclusion is that, setting aside the arguments for and against the principle of community rating itself, the unilateral imposition of strict community rating upon HMOs and not upon other prepaid health care and health insurance plans works an unfair, uncompetitive hardship on HMOs. Therefore, it seems to me that this requirement in the present HMO Act should be amended, and that the issue of community rating should be handled in a larger legislative context, such as national health insurance, involving all health care and health insurance plans.

My first supporting point is that, in general, community-rated plans are at a competitive disadvantage with respect to experience-rated plans. (By experience rating is meant that premium rates are varied according to the prior cost experience of the subscriber group or individual.) An experience-rated plan can offer a lower premium to groups and individuals with more

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favorable experience. This tends to leave community-rated plans with groups and individuals having less favorable experience, thus making the community-rated plan even less competitive.* For example, in the early years of health insurance, many Blue Cross and other plans used the community rating principle. The rapid advent of experience-rated plans in the 1940's forced these plans to move away from community rating in order to compete, so that now very few insurance plans use community rating. On the other hand, HMOs have been sufficiently efficient that even with community rating many HMOs have been able to compete favorably with experience-rated plans in many areas of the country. However, for a variety of historical and market reasons, many HMOs also now depart significantly from strict community rating. To unilaterally deny HMOs the right to rate flexibly to meet the demands of their market would appear to be competitively unfair and may inhibit HMO growth in some areas of the country.

My second supporting point is that the requirement of community rating can work particular hardship on new, small HMOs. New HMOs scrambling to get into the market cannot exercise great discretion over which subscriber groups they enroll first. In some cases, their first few subscriber groups have been older or otherwise higher cost groups. The requirement of strict community rating then prejudices their premium upward, and their competitive ability to enroll further groups is diminished. If the objective of the HMO Act is to encourage the formation of new HMOs, the community rating requirement

* If HMOs are compelled to open enroll--e.g., enroll individuals without regard to their medical risk--as well as community-rate, which the present HMO Act requires them to do, community rating becomes even more competitively prejudicial.

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can inhibit their ability to get an initial large base of subscribers from which to build.

My third supporting point is that the requirement of strict community rating works a hardship on many established HMOs. As mentioned earlier, due to a variety of historical and market factors, many established HMOs deviate from strict community rating in a variety of ways for at least some of their member groups. Different rate structures are used for different member groups often at the insistence of the member group itself, reflecting relationships which go back many years. For example, while few HMOs use prior experience of a group in establishing rates--the most efficient HMO record systems often preclude the ability to determine group experience separately--at least one HMO has for fifteen years had a large member group which is experienced rated at the group's insistence. In many HMOs, some member groups insist on a three-step rate structure (separate rates for singles, couples and families), while other member groups desire a two-step (single and families) or one-step (all subscribers have the same rate independent of family size) rate structure, so that individuals and families of similar composition in these HMOs do not all pay the same premium even though no prior cost experience is taken into account. Some HMOs take general demographic factors--age, sex, family composition, etc.--at least partially into account in establishing group rates. In some HMOs market pressures have prevented the HMO from raising group rates as fast with some groups as others. In one HMO, individual and group rates differ based on whether the enrollee made an initial membership payment. There are perhaps as many other examples as there are HMOs. To require uniform rate structures on a community basis will be disruptive of these long-standing relationships and may cause loss of some member groups

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to these HMOs. At the very least, considerable time will be needed for HMOs to negotiate complying rate structures with their member groups.

My fourth and final supporting point is that community rating seems more properly a national health insurance issue. The requirement of community rating is neither peculiar nor essential to HMOs, and at the least would appear more appropriately handled outside the context of the HMO Act. It is not necessary to require community rating for HMOs to have incentives for efficient, effective performance. Most HMOs community-rate because it is administratively more efficient to do so, and because they believe in community rating as a social objective. Thus most HMOs will community-rate even in the absence of legislative requirement, except where the market compels them to do otherwise. The social objective of community rating is to assure that the financial burden of illness is shared more equally among the well and the sick, and that persons with high medical risk can buy coverage at an affordable price. Community rating is one means to this larger objective. But this objective is surely a question of national scope. And the best means to accomplish this objective, whether by community rating or some other less implicit private or public subsidy, is still sharply debated by experts. To unilaterally impose this social objective by law through a particular means--community rating--on an infant sector of the health care system which the Congress is trying to encourage seems not only unfair but counter-productive.

In conclusion I would like to raise three possibilities for dealing with the requirement of community rating in the HMO Act:

- First, at a minimum, InterStudy, along with the other organizations of the so-called consensus group represented here today, supports the Hastings-Rogers amendment to postpone the requirement for community rating five years. This will give existing HMOs time to come into compliance, give HEW time to define in regulation what variations in existing rate structures meet the present law, and permit Congress to assess the situation after five years to see if any further adjustments in the law seem warranted.
- Second, and here I speak only for InterStudy and not other members of the consensus group, community rating might not only be postponed but broadened in definition so that HMOs might more flexibly deal with market situations and with their existing rate structures. Such a broadened definition might, for example, exclude the use of prior cost experience but include some allowance for demographic risk factors and other variations in establishing rates. However, it is probably impossible to write even a broadened definition which does not work some competitive hardship on at least some new or existing HMOs.
- Finally, and this is InterStudy's best judgment, the requirement for community rating could be deleted from the HMO Act, and the issue of how best to financially protect people with high medical risk, whether by community rating or some other means, could be addressed in a larger context, such as national health insurance or other broad legislation affecting all health care and health insurance plans.

Senator KENNEDY. Well, I think it will be very worthwhile for us to find out from each of the groups, not right now, what they mean by community rating.

Everybody is waiting until we get some kind of health insurance to resolve all these particular problems. What we are trying to establish here is at least some policy issues. We have tried to build in some degree of flexibility, but also try to develop a competitive system for the delivering of health care.

I, for one, am extremely reluctant to throw in the towel on that important kind of experiment. I am informed at the present time that HEW can hardly handle applications of HMO's that they now have.

If they abolish this, they will get flooded with a whole number of additional requests.

I would like to ask if each of you, not now, but in supplementing your statements, if you would get together on how you exactly define community rating. If you could do that for us, we would appreciate it. It is subject to a wide variety of different interpretations. Would you do that for us?

Mr. McCLURE. We will try to do that, Senator. I think you will find the definition of community rating will vary for each plan; that is, the rating system of each plan will differ whether or not they call themselves community rated.

We will try to get that information to you.

Our next point, if it is agreeable to everyone, is the issue of loan guarantees to for-profit HMO sponsors. This will be addressed by Mr. Richard Hoffman.

Mr. HOFFMAN. I am Richard Hoffman, vice president and actuary, the Equitable Life Assurance Society of the United States.

I am here today on behalf of the Health Insurance Association of America. The HIAA consists of 325 insurance companies which are responsible for about 85 percent of all health insurance written by insurance companies in the United States today.

Our industry has been involved in and has supported the HMO movement from its inception. Presently, over 50 of our companies have relationships in one way or another with more than 70 HMO projects, and 23 of these are operational.

While my responsibility this morning, as a member of the consensus group, is to address myself to guarantees of loans made by non-Federal lenders, I want to emphasize that the Health Insurance Association strongly endorses the entire package of provisions of S. 1926.

Additional statements of our support are expressed in letters I have from senior executive officers from Equitable, Metropolitan, Connecticut General, and Prudential Insurance Cos.

I would appreciate your having these letters inserted into the record at this point.

[The letters referred to follow:]

THE EQUITABLE LIFE ASSURANCE SOCIETY
OF THE UNITED STATES
New York, New York

December 12, 1975

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health
Committee on Labor and Public Welfare
U. S. Senate
Washington, D. C.

Dear Senator Kennedy:

I would like to add my support and that of the Equitable Life Assurance Society of the United States to S. 1926, the Health Maintenance Organization Amendments of 1975.

While there was rapid growth of HMOs in anticipation of the Health Maintenance Organizations Act of 1973, P.L. 93-222, and there has been considerable interest since then, the Act has not stimulated the further growth of HMOs and it can be said has not resulted in a "fair market test" of the HMO concept. This can be attributed in large measure to provisions of P.L. 93-222, which S. 1926 would correct.

The Equitable has been actively involved in HMO developmental activities for the last five years. Our recent experiences reinforce our belief that some changes in P.L. 93-222 are urgently needed, if the marketing of HMO benefits is to be enhanced. Many employers indicate they will not offer the HMO option to their employees until the regulations for P.L. 93-222 are final and some of its ambiguity is clarified. Therefore, the need for this legislation is urgent.

If HMOs are to have an important influence on the nation's health care delivery system, then they cannot be saddled with requirements that place them at a competitive disadvantage. For example, the mandated benefit provisions of P.L. 93-222 place HMOs in a disadvantageous position vis-a-vis existing health insurance plans.

I hope that the spirit which gave birth to the "consensus" amendments will lead to its early passage.

Sincerely,

M. D. Miller
Vice Chairman of the Board

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
Newark, New Jersey

December 12, 1975

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health
Committee on Labor and Public Welfare
U. S. Senate
Washington, D. C.

Dear Mr. Chairman:

The Prudential Insurance Company of America endorses S. 1926, the amendments to the Health Maintenance Organization Act of 1973.

The Health Maintenance Organization Act of 1973 intended to provide Federal assistance and encouragement to establish and expand health maintenance organizations. It also implied that the private sector should be encouraged to sponsor and develop more HMOs. While there is evidence that some development has occurred, there has not been the growth originally sought by the Congress and those institutions and persons involved in the health care delivery field.

To survive, an HMO must compete successfully in the marketplace with other forms of health insurance and service benefit plans. Flexibility must be offered to design plans of services and approaches to pricing and marketing that permit the HMO to meet its competition. Rigidities in the Act impair that freedom.

The amendments will permit HMOs to market competitively, but they still encourage the offering of a comprehensive spectrum of services to HMO plan members.

The private sector has been reluctant to move into HMO development for a number of reasons including its concern over requirements of the Act that make it difficult to enroll sufficient numbers of members for HMOs to become successful business entities. These amendments will lower market barriers that discourage entry and experimentation on the part of carriers, hospital and physician groups.

It is also desirable to extend the funding under the Act. Nearly two years of prime development and expansion time have been lost while the necessary regulations have been developed.

We urge enactment of the bill.

Sincerely,

Fredrick E. Rathgeber
Executive Vice President

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
Hartford, Connecticut

December 12, 1975

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health
Committee on Labor and Public Welfare
U. S. Senate
Washington, D. C.

Dear Mr. Chairman:

I am pleased to write to express Connecticut General Life Insurance Company's strong support for the amendments to the Health Maintenance Organization Act of 1973, S. 1926.

Connecticut General's interest in, and practical support for, the concept of prepaid health care delivery are both long-standing and well-known, this Company having been among the very first insurance companies to directly sponsor a health maintenance organization. We continue to believe that private industry is well-equipped by tradition and experience to play a significant role in the development of a viable nationwide system of health maintenance organizations providing a genuine alternative to, and complementing, the present system of health care delivery.

It is in this spirit that we welcome the recognition given in the Act to private sector participation in the prepaid health care delivery experiment. It is also for this reason that we support any move that seeks to remove those technical and substantive obstacles to such participation which many of us believe have been created, perhaps inadvertently, by the Act. We see the amendments to the Act as an essential step towards removing such obstacles and accordingly we are glad to endorse them.

Sincerely,

Robert D. Kilpatrick
Senior Vice President

METROPOLITAN LIFE
New York, New York

December 12, 1975

Honorable Edward M. Kennedy, Chairman
Subcommittee on Health
Committee on Labor and Public Welfare
U. S. Senate
Washington, D. C.

Dear Senator Kennedy:

The Metropolitan Life Insurance Company wishes to express its full support for the enactment of the Health Maintenance Organization Amendments of 1975.

The purpose of the HMO Law of 1973, to foster the development of Health Maintenance Organizations as a viable alternative to the present system of health care delivery in the United States, has been actively supported by Metropolitan. The lack of progress in the past 24 months has indicated that changes in the HMO law are essential in order to achieve the desired results. The HMO Amendments of 1975 are improvements which should allow a more competitive atmosphere in which a qualified HMO might receive a "fair market test."

Metropolitan is keenly aware of the initial development problems associated with high start-up costs and the traditionally slow enrollment growth of most new HMOs. These problems have been compounded by the requirements of the present law for basic services, community rating, and the annual open enrollment for individual membership. Relief in these areas, as well as more flexibility with respect to supplemental health services, will allow qualified HMOs to market a more competitively priced health benefit package. Additionally, the present requirement that medical groups have as their principal professional activity the provision of health services to members of HMOs is unrealistic.

The proposed amendments offer significant relief in these areas where the legislation has created barriers. Metropolitan has been disappointed that the 1973 HMO Law has done more to frustrate HMO development than to encourage their growth. We believe that swift enactment of these amendments will help to reverse what has occurred.

Sincerely,

W. S. Thomas
Executive Vice President

Mr. HOFFMAN. The HIAA believes that enactment of S. 1926 will furnish the stimulus necessary for the growth of HMO's and will give them a fair chance to compete effectively within the health care delivery system. The ultimate beneficiary will be the consumer, who will thus be given the opportunity to choose an alternative health delivery system which will improve access, enhance quality, and help reduce the cost of health care.

Mr. Chairman, as you know, Federal financial assistance under Public Law 93-222 is provided in various forms, through grants, contracts, Federal loans, and guarantees of loans made by non-Federal lenders. The intent of the law seems clear: both Federal and non-governmental funds were to be the source of financing the development of qualified HMO's.

However, to date, only Federal funds have been used. In fact, out of about 400 applications for financial assistance received by the Department of HEW to date, only two have involved a guarantee of non-Federal funds.

We believe that this is the result of several deficiencies in the law as enacted—deficiencies, Mr. Chairman, which your subcommittee avoided in its original proposal. Regrettably, your approach did not prevail, although there was considerable support for it.

The purpose of the proposed amendments to sections 1304 and 1305 is to restore the subcommittee's original approach and to correct these deficiencies. Specifically, the amendments would remove several restrictions to HMO's seeking Federal guarantees of loans made by non-Federal lenders for planning, initial development, and initial operation costs.

This would be accomplished by eliminating the requirements that an HMO: (1) Be a private—other than nonprofit—entity; and (2) serve a medically underserved population.

S. 1926 does provide that in considering applications for loan guarantees, the Secretary shall give special consideration to HMO's which will serve medically underserved populations, and we support that proviso, of course.

These same amendments were considered by the House Subcommittee on Public Health and Environment, but were altered, and thus the deficiencies remain substantially uncorrected in the recently passed H.R. 9019.

Our consensus group firmly believes that the amendments to 1304 and 1305 proposed in S. 1926 will better serve the original intent of the law by encouraging the infusion of nongovernmental funds into the HMO movement. This is particularly important during this time when scarce Federal funds are vitally needed for other purposes. Thank you.

[The prepared statement of the Health Insurance Association of America, as presented by Mr. Hoffman, follows:]

STATEMENT BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
SENATE LABOR AND PUBLIC WELFARE COMMITTEE
ON
S. 1926

RICHARD H. HOFFMAN
VICE PRESIDENT AND ACTUARY
THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES
ON BEHALF OF
THE HEALTH INSURANCE ASSOCIATION OF AMERICA

DECEMBER 12, 1975

Thank you, Mr. Chairman. I am Richard H. Hoffman, Vice President and Actuary, The Equitable Life Assurance Society of the United States. I am here today on behalf of the Health Insurance Association of America. The HIAA consists of 325 insurance companies which are responsible for about 85% of all health insurance written by insurance companies in the United States today.

Our industry has been involved in and has supported the HMO movement from its inception. Presently over 50 of our companies have relationships in one way or another with more than 70 HMO projects, and 23 of these are operational.

While my responsibility this morning, as a member of the "Consensus Group," is to address myself to guarantees of loans made by non-federal lenders, I want to emphasize that the Health Insurance Association strongly endorses the entire package of provisions of S. 1926.

The HIAA believes that enactment of S. 1926 will furnish the stimulus necessary for the growth of HMOs and will give them a fair chance to compete effectively within the health care delivery system. The ultimate beneficiary will be the consumer, who will thus be given the opportunity to choose an alternative health delivery system which will improve access, enhance quality, and help reduce the cost of health care.

Mr. Chairman, as you know, federal financial assistance under Public Law 93-222 is provided in various forms, through grants, contracts, federal loans and guarantees of loans made by non-federal lenders. The intent of the law seems clear: Both federal and non-governmental funds were to be the source of financing the development of qualified HMOs.

However, to date, only federal funds have been used. In fact, out of about 400 applications for financial assistance received by the Department of HEW to date, only two have involved a guarantee of non-federal funds.

We believe that this is the result of several deficiencies in the law as enacted, deficiencies, Mr. Chairman, which your Subcommittee avoided in its original proposal. Regretably, your approach did not prevail, although there was considerable support for it.

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These same amendments were considered by the House Subcommittee on Public Health and Environment, but were altered and thus the deficiencies remain substantially uncorrected in the recently passed H.R. 9019. Our "Consensus Group" firmly believes that the amendments to 1304 and 1305 proposed in S. 1926 will better serve the original intent of the Law by encouraging the infusion of non-governmental funds into the HMO movement. This is particularly important during this time when scarce federal funds are vitally needed for other purposes.

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Senator KENNEDY. Are you saying that we should limit open enrollment or provide some kind of underwriting or subsidy for HMO's?

Mr. HOFFMAN. No. This has to do with the guarantee of funds, private funds, for those HMO's which are not in underserved areas. It does not address the issue of open enrollment.

Senator KENNEDY. All right. Would we have much of a problem on the issue of open enrollment if we require all the insurance companies to have an open enrollment policy, too, and therefore eliminate competitive disadvantage that the HMO's have?

Mr. HOFFMAN. I would answer in this way, that if insurance companies did have open enrollment mechanisms, that would solve the problems of the HMO's.

Senator KENNEDY. We can go either way and meet the competitive problem, can we not?

Mr. HOFFMAN. In theory, yes. In practice, we firmly believe that any such approach on a Federal level ought to be through the national health insurance route as part of the total program.

Senator KENNEDY. Do you have a position on health insurance? You all talk about it as being a catchall for these various problems. You are all rather specific in what you want us to do to change this act until we get health insurance.

Have you gotten together on health insurance proposals?

Mr. McCURE. Our point is that we do not want unilateral imposition of solutions of these problems on one small group of organizations and consumers. That is all.

We have truly a cost program. Incidentally, concerning your question, there is always the tendency of the high risk consumer to choose the more comprehensive package available to him.

Insofar as HMO's have a comprehensive package, they would tend to get higher risks and apparently do.

Senator KENNEDY. You can understand our point of view as to why we should be allocating funds as well. I believe that it is time we start trying to provide some health care to people.

What we are attempting to do is to make sure the legislation we fashion or develop is going to be available to people who need it.

We have tried to put into the legislation the kind of waivers so that it would not, if the provisions are complied with, completely hamstring the possibilities for the development of alternative delivery service.

Mr. HOFFMAN. I might point out, Senator, that States are presently very active in the area of relevant legislation, to encourage open enrollments on the part of health insurance companies as well as HMO's. In fact, several States have already passed such legislation. It is being considered by the National Association of Insurance Commissioners as well.

Senator KENNEDY. What is the position of your company?

Mr. HOFFMAN. The position of our company is that if it is going to be done on a national basis, it should be part of a total national health insurance legislation.

Mr. ANDERSON. I think it should be recognized from the economic viewpoint that open enrollment really is a taxing system. What it does is it taxes the groups with better experience, the cost of whose care is less, for the benefit of the groups whose cost is greater.

As within the other taxing system, it simply is a question of how do you spread that tax. Is the way in which you do it fair?

If you were to mandate that all insurance companies have to have open enrollment, what it means is the employer and union groups will simply subsidize the cost of those groups with less favorable experience. That is, I suppose, one way to approach it.

I think it would be a big surprise politically, among other things, to the groups that now have established insurance relationships that find that that is the mechanism through which the problem of the higher risk people is dealt with.

Mr. PYLE. I think the problem that we face is that we all believe that HMO's are extremely useful in and of themselves as an answer to part of the problem of health care delivery in the United States. Specifically, the problem of controlling costs and the problem of improving access, and I think many of us feel that there is sufficient difficulty in getting one of these started, and even in keeping it going, in building it, that it is very difficult to burden this small part of the industry with picking up this health care cost.

We do not really know how big it might be because we are talking about 5 percent of the market, and you have got 95 percent of the market out there being denied applications—we have phone calls coming in all the time, coming into our market office, people who get refused by the whole insurance industry, want to come into HMO.

If we have to take rejects of 95 percent of the marketplace and spread that 35 percent of extra cost over our relatively small membership—54,000 out of 3 million in Greater Boston—it just becomes extremely burdensome.

While we would like to see that problem corrected, and I think many of these organizations, as I look at their policies, are much broader in what they are doing and much more liberal in terms of, for instance, allowing group conversions—in the Harvard plan, if someone leaves their job, and is in terrible health, they can go right into our nongroup plan, and they cannot do that in Blue Cross. They go into the lowest level of nongroup coverage by Blue Cross.

I think you find this throughout the prepaid group practice movement, we do a higher level job of providing access to people who are sick. We cannot go quite as far as you would suggest.

Mr. McCLURE. Senator, our next issue is the dual choice provision. This will be addressed by Mr. Michael Henry, senior director, alternative delivery systems, of the Blue Cross Association.

Mr. HENRY. I am Michael E. Henry, senior director of alternative delivery systems for the Blue Cross Association, which is the national organization representing the country's 70 Blue Cross plans.

We are pleased to join the other organizations represented on this panel in support of S. 1926, the Health Maintenance Organization Amendments of 1975. We have been gratified that the House, in its consideration of H.R. 9019, has voted overwhelming support of the HMO amendments, and we fully appreciate this subcommittee's interest in necessary and beneficial modifications of the HMO Act of 1973.

We support the HMO amendments with the conviction that their passage by the Senate will produce an even more effective law and, consequently, more effective health care alternatives from which today's cost and quality minded consumers can select.

Also, I bring with me today a letter from the Blue Cross Association expressing support of the Blue Cross organization for S. 1926.

In appearing today, I speak from the perspective and experience of the Blue Cross organization's involvement in alternative delivery systems and HMO's. This commitment dates back to the late 1960s—and earlier for some plans—and has resulted in the sponsorship or co-development of more than 100 new and currently operating HMO's.

One-third of all Blue Cross plans are involved in varying capacities with these HMO's nationwide, serving nearly 500,000 subscribers.

Of the 170 operational HMO organizations listed by the Department of Health, Education, and Welfare in its May 1975 HMO program status report, one-third have been cosponsored by, or operated with the involvement of their local Blue Cross plan. Our investment in fostering the development of HMO's has been significant—approximately \$38 million so far.

It is, therefore, with a real interest in fostering the growth of successful HMO's that I testify in behalf of S. 1926. The dollars and expertise devoted by the Blue Cross organization to providing alternative delivery systems to consumers have helped produce many effective HMO programs. With the passage of the HMO amendments and the enhancements they would bring, we would look forward to our continued involvement in helping to make the HMO movement a continuing success.

The Blue Cross organization supports S. 1926 in its entirety. The experience of our plans leads to their conviction that only through repeal of the HMO Act's mandatory open enrollment and community rating provisions can we assure that developing HMO's will not be prevented, by artificial market conditions, from becoming financially strong.

Similarly, we are convinced that by not requiring physicians to devote at least 51 percent of their time to a group practice HMO, we will see more rapid and economical development of HMO programs. We feel this is particularly justified, given the substantial cost of new HMO development and the difficulty inherent in creating new physician resources.

The majority of Blue Cross Plan involved HMO's have utilized this approach of capitalizing on existing physician resources and have found the gradual phasing of these patterns into a prepaid system to be both effective and economical.

As the main focus of my testimony, my particular assignment as a participant of this panel is to outline the basis for our support of section 10(1) of S. 1926, which would amend section 1310, the so-called dual choice section of the HMO Act, to mandate an HMO option for groups of employees only when at least 25 reside in the service area of a given qualified HMO.

Section 1310 of the HMO Act of 1973 has the present effect of requiring that any employer subject to the dual choice provision of the act must offer the HMO option to any eligible employee, even if only one resides in an HMO area.

Large corporations with substantial payrolls have employees living in many political jurisdictions, and potentially many different HMO service areas. A large New York City based corporation, for example, has one employee who resides in Philadelphia and commutes. If the

employee elects to enroll, present section 1310 would require the employer to set up the machinery to maintain records, pay premiums, and service the account of this one employee as a member of a qualified HMO in Philadelphia.

The administrative costs of such an operation would be enormous, not to mention the personnel and data processing that would be required.

The HMO likewise would have the administrative burden and expense of handling the transaction as an individual enrollment rather than the cost-effective group enrollment that the act contemplates.

Raising the minimum number of employees in an HMO service area to 25 in order to bring the mandated option into effect, as provided in section 10(1) of S. 1926, would be cost effective and would greatly improve the practical potential of dual choice to provide the access to market so fundamental to HMO development.

I thank you, Mr. Chairman and members, for this opportunity to testify in support of S. 1926.

Thank you.

[The prepared statement of the Blue Cross Association, as presented by Mr. Henry, follows:]

A STATEMENT ON

S. 1926

HEALTH MAINTENANCE ORGANIZATION

AMENDMENTS OF 1975

By:

BLUE CROSS ASSOCIATION

Michael E. Henry
Senior Director
Alternative Delivery Systems

PRESENTED TO THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

December 12, 1975

Mr. Chairman and members of the subcommittee, I am Michael E. Henry, Senior Director of Alternative Delivery Systems for the Blue Cross Association, which is the national organization representing the country's seventy Blue Cross Plans.

We are pleased to join the other organizations represented on this panel in support of S. 1926, the Health Maintenance Organization Amendments of 1975. We have been gratified that the House, in its consideration of H.R.9019, has voted overwhelming support of the HMO Amendments, and we fully appreciate this subcommittee's interest in necessary and beneficial modifications of the HMO Act of 1973. We support the HMO Amendments with the conviction that their passage by the Senate will produce an even more effective law and, consequently, more effective health care alternatives from which today's cost and quality-minded consumers can select.

In appearing today, I speak from the perspective and experience of the Blue Cross organization's involvement in alternative delivery systems and HMOs. This commitment dates back to the late 1960's (and earlier for some Plans) and has resulted in the sponsorship or co-development of more than one hundred new and currently operating HMOs. One-third of all Blue Cross Plans are involved in varying capacities with these HMOs nationwide, serving nearly 500,000 subscribers. Of the 170 operational HMO organizations listed by the Department of Health, Education and Welfare in its May, 1975, HMO Program Status Report, one-third have been co-sponsored by, or operated with the involvement of their

local Blue Cross Plan. Our investment in fostering the development of HMOs has been significant - approximately \$38 million so far.

It is, therefore, with a real interest in fostering the growth of successful HMOs that I testify in behalf of S. 1926. The dollars and expertise devoted by the Blue Cross organization to providing alternative delivery systems to consumers have helped produce many effective HMO programs. With the passage of the HMO Amendments, and the enhancements they would bring, we would look forward to our continued involvement in helping to make the HMO movement a continuing success.

The Blue Cross organization supports S. 1926 in its entirety. The experience of our Plans leads to their conviction that only through repeal of the HMO Act's mandatory open enrollment and community rating provisions can we assure that developing HMOs will not be prevented, by artificial market conditions, from becoming financially strong. Similarly, we are convinced that by not requiring physicians to devote at least 51% of their time to a group practice HMO, we will see more rapid and economical development of HMO programs. We feel this is particularly justified, given the substantial cost of new HMO development and the difficulty inherent in creating new physician resources. The majority of Blue Cross Plan-involved HMOs have utilized this approach of capitalizing on existing physician resources and have found the gradual phasing of these patterns into a prepaid system to be both effective and economical.

As the main focus of my testimony, my particular assignment as a participant of this panel is to outline the basis for our support of Section 10 (1) of S. 1926, which would amend Section 1310, the so-called dual choice section of the HMO Act, to mandate an HMO option for groups of employees only when at least 25 reside in the service area of a given qualified HMO.

Section 1310 of the HMO Act of 1973 has the present effect of requiring that any employer subject to the dual choice provision of the Act must offer the HMO option to any eligible employee, even if only one resides in an HMO area.

Large corporations with substantial payrolls have employees living in many political jurisdictions, and potentially many different HMO service areas. A large New York City based corporation, for example, has one employee who resides in Philadelphia and commutes. If the employee elects to enroll, present Section 1310 would require the employer to set up the machinery to maintain records, pay premiums and service the account of this one employee as a member of a qualified HMO in Philadelphia.

The administrative costs of such an operation would be enormous, not to mention the personnel and data processing that would be required.

The HMO likewise would have the administrative burden and expense of handling the transaction as an individual enrollment rather than the cost-effective group enrollment that the Act contemplates.

Raising the minimum number of employees in an HMO service area to 25 in order to bring the mandated option into effect as provided in Section S. 1926

would be cost-effective and would greatly improve the practical potential of dual choice to provide the access to market so fundamental to HMO development.

I thank you Mr. Chairman and members for this opportunity to testify in support of S. 1926.

Mr. McCLURE. Our last issue is on the dequalification process, addressed by Mr. James Anderson, counsel, Connecticut General Life Insurance Co.

Mr. ANDERSON. Mr. Chairman, I am James E. Anderson, counsel of Connecticut General Life Insurance Co.

I am accompanied today by Theodore Lutins, of the Health Insurance Association of America.

First, Mr. Chairman, let me say that we appreciate your continued interest in and efforts on behalf of the HMO movement. We are looking forward to working with you and your committee in our mutual desire to advance HMO development.

My assignment, as part of the consensus group, is to outline section 11 of S. 1926, which would amend section 1312 of the act, relating to continuing regulation of qualified HMO's. The amendment is intended to affect those HMO's which have not received Federal financial assistance.

It would permit the Secretary to dequalify such HMO's in lieu of authorizing him to bring suit against the HMO to compel its continued compliance with the organizational and operational requirements of the act. The amendment would also create explicit procedural safeguards relative to the dequalification process.

This change has great practical significance for an HMO contemplating qualification for purposes of section 1310. At present, there is no provision for dequalification of a qualified HMO, regardless of changes in the HMO's circumstances affecting its ability to continue to meet the act's requirements or regardless of changes of interpretation or policy in the administration of the act.

The proposed amendment would remedy this situation.

Two questions might be raised as to the approach taken in the proposed amendment. First, why not simply authorize the Secretary to permit the dequalification of an HMO upon such conditions as he deems advisable?

Such an approach would leave the HMO in an untenable position in several respects.

First, the act itself is highly complex. Many questions exist as to its interpretation. An HMO cannot determine with any certainty just what regulatory expectations will be placed upon it.

Second, extreme viewpoints exist in some quarters as to the social obligations which HMO's should fulfill, the manner in which they should operate and controls to which they should be subject, irrespective of the consequences to the financial viability of the HMO. It is entirely conceivable that stringent policies may be adopted at the administrative level in the future which the HMO could not reasonably foresee.

The question of open enrollment waiver is certainly one of those issues.

Third, every HMO is in a somewhat unique situation. Management decisions it makes must take into account its particular relationship with providers and its resulting fixed costs, current membership level and growth it will require for financial viability, marketing potential within its service area, and cost levels of typical employee benefit plans in this area, among other things.

It may be anticipated that some policies developed under the Act, while reasonable in relation to most HMO's, will be impractical in relation to a particular HMO. Thus, it is impossible to create any objective standard as to what particular conditions would justify dequalification of the HMO.

The second question is essentially this, would not the proposed amendment make it possible for an HMO to qualify under section 1310 with no intention of remaining permanently qualified—or to dequalify without any real grounds and significantly change its operations, thereby damaging its members?

First, in view of the crucial importance to the HMO of gaining and maintaining an adequate membership level, it is unrealistic to think that an HMO would act cavalierly in contemplating possible dequalification.

To avoid suffering a devastating decrease in enrollment, it would be required to explain such a step to its members and participating employers in a convincing way and obtain their acquiescence. It would be concerned that competing plans might try to associate its dequalification with decline in the quality of its product. And, of course, dequalification would mean that other qualified HMO's could use the dual choice mandate to invade its participating employers, thereby cutting into its enrollment.

Second, this concern ignores the impact of dual choice. The whole premise of the dual choice mandate under the act is that employees should, can, and will intelligently exercise an option as between HMO membership and conventional indemnity benefits. If the employer continues to offer the nonqualified HMO, the employees will exercise an effective control.

If the quality of the HMO declines, they will simply opt back to the indemnity plan. To deny that the employees are capable of making a sound choice in this regard is to deny the whole legislative premise underlying the dual choice mandate.

In summary, Mr. Chairman, given all the inherent complexities and uncertainties, the HMO which has not received Federal financial assistance should not be required to make an irrevocable, unconditional commitment to qualification.

If such HMO finds that it cannot feasibly continue to meet the act's requirements, and if it is willing to suffer the possible stigma of dequalification and give up its status under section 1310, it should be permitted to do so.

Thank you.

[The prepared statement of the Connecticut General Life Insurance Co., as presented by Mr. Anderson, follows:]

STATEMENT OF THE
HEALTH INSURANCE ASSOCIATION OF AMERICA

ON
HEALTH MAINTENANCE ORGANIZATION
AMENDMENTS OF 1975
S. 1926

PRESENTED BY
JAMES E. ANDERSON
COUNSEL
CONNECTICUT GENERAL LIFE INSURANCE COMPANY

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

December 12, 1975

Mr. Chairman, I am James E. Anderson, Counsel of Connecticut General Life Insurance Company. I am accompanied today by Theodore Lutins of the Health Insurance Association of America. First, Mr. Chairman, let me say that we appreciate your continued interest in *and* efforts on behalf of the HMO movement. We are looking forward to working with you and your committee in our mutual desire to advance HMO development. My assignment as part of the Consensus Group is to outline Section 11 of S. 1926, which would amend Section 1312 of the Act, relating to continuing regulation of qualified HMOs. The amendment is intended to affect those HMOs which have not received federal financial assistance. It would permit the Secretary to dequalify such HMOs in lieu of authorizing him to bring suit against the HMO to compel its continued compliance with the organizational and operational requirements of the Act. The amendment would also create explicit procedural safeguards relative to the dequalification process.

This change has great practical significance for an HMO contemplating qualification for purposes of Section 1310. At present, there is no provision for dequalification of a qualified HMO, regardless of changes in the HMO's circumstances affecting its ability to continue to meet the Act's requirements or regardless of changes of interpretation or policy in the administration of the Act. The proposed amendment would remedy this situation.

Two questions might be raised as to the approach taken in the proposed amendment. First, why not simply authorize the Secretary to permit the dequalification of an HMO upon such conditions as he deems advisable?

Such an approach would leave the HMO in an untenable position in several respects.

First, the Act itself is highly complex. Many questions exist as to its interpretation. An HMO cannot determine with any certainty just what regulatory expectations will be placed upon it.

Second, extreme viewpoints exist in some quarters as to the social obligations which HMOs should fulfill, the manner in which they should operate and controls to which they should be subject, irrespective of the consequences to the financial viability of the HMO. It is entirely conceivable that stringent policies may be adopted at the administrative level in the future which the HMO could not reasonably foresee.

Third, every HMO is in a somewhat unique situation. Management decisions it makes must take into account its particular relationship with providers and its resulting fixed costs, current membership level and growth it will require for financial viability, marketing potential within its service area, and cost levels of typical employee benefit plans in this area, among other things. It may be anticipated that some policies developed under the Act, while reasonable in relation to most HMOs, will be impractical in relation to a particular HMO. Thus, it is impossible to create any objective standard as to what particular conditions would justify dequalification of the HMO.

The second question is essentially this: Would not the proposed amendment make it possible for an HMO to qualify under Section 1310 with no intention of remaining permanently qualified - or to dequalify without any

real grounds and significantly change its operations, thereby damaging its members?

First, in view of the crucial importance to the HMO of gaining and maintaining an adequate membership level, it is unrealistic to think that an HMO would act cavalierly in contemplating possible dequalification. To avoid suffering a devastating decrease in enrollment, it would be required to explain such a step to its members and participating employers in a convincing way and obtain their acquiescence. It would be concerned that competing plans might try to associate its dequalification with decline in the quality of its product. And of course, dequalification would mean that other qualified HMOs could use the dual choice mandate to invade its participating employers, thereby cutting into its enrollment.

Second, this concern ignores the impact of dual choice. The whole premise of the dual choice mandate under the Act is that employees should, can and will intelligently exercise an option as between HMO membership and conventional indemnity benefits. If the employer continues to offer the non-qualified HMO, the employees will exercise an effective control. If the quality of the HMO declines, they will simply opt back to the indemnity plan. To deny that the employees are capable of making a sound choice in this regard is to deny the whole legislative premise underlying the dual choice mandate.

In summary, Mr. Chairman, given all the inherent complexities and uncertainties, the HMO which has not received federal financial assistance should not be required to make an irrevocable, unconditional

commitment to qualification. If such HMO finds that it cannot feasibly continue to meet the Act's requirements, and if it is willing to suffer the possible stigma of dequalification and give up its status under Section 1310, it should be permitted to do so.

Senator NELSON. You are talking about an HMO that has received no Federal assistance?

Mr. ANDERSON. Correct.

Senator NELSON. By that you are talking about specific financial assistance for the creation of the HMO, not financial assistance related to insurance plans or medicare, or medicaid?

Mr. ANDERSON. No.

Of course, the act contains two benefits. One is specific financial assistance and the other is dual choice.

What I am speaking to is HMO which is qualified solely with respect to dual choice and has not received assistance under the act.

Senator NELSON. All right. Thank you.

Mr. McCURE. That completes our testimony.

Senator KENNEDY. I want to thank you very much for your panel's presentation. Obviously, a great deal of thought has gone into all of these issues.

We have had a chance on occasion to meet informally to review these issues and we want to give you the assurances that we will get a chance to evaluate them in the committee.

We appreciate your appearance here this morning.

Senator NELSON. I do not recall whether you were here, but in part of our discussion, Mr. Chairman, I raised the question of whether they would be prepared to submit for the record the comparative costs for comparable service, as supplied under open enrollment in the Marshfield Clinic versus other plans, and it was suggested by the representative of a Kaiser-Permanente that they discuss this with staff and work it out.

Is that all right?

Senator KENNEDY. Sure. We will work that out. Thank you very much.

Our next witness this morning is Dr. Ben Lawton, President of the Marshfield Clinic in Marshfield, Wis.

Dr. Lawton is a member of the American Medical Association, the Wisconsin Surgical Society, the American Thoracic Society, and the Milwaukee Academy of Surgery. He is also a fellow with the American College of Surgeons. He was President of the Wisconsin Surgical Society from 1971 till 1972. He is presently chairman of the Governor's Health Policy and Program Council.

We welcome you here this morning, Dr. Lawton, and are anxious to hear your testimony.

Senator NELSON. Dr. Ben Lawton is an old friend from college days. I am pleased to welcome him here today.

He is also Clinical Professor of Surgery at the University of Wisconsin Medical School.

We are pleased to see you here. He is accompanied by Mr. Gregory Nycz, director of information systems, Marshfield Medical Foundation.

STATEMENT OF BEN R. LAWTON, M.D., PRESIDENT, MARSHFIELD CLINIC, MARSHFIELD, WIS., ACCOMPANIED BY GREG NYCZ, DIRECTOR, INFORMATION SYSTEMS, MARSHFIELD MEDICAL FOUNDATION

Dr. LAWTON. I am pleased to be here, and what has to be a minority report, since almost all the audience left.

Senator KENNEDY. That is unfortunate.

Dr. LAWTON. I was fully aware when I prepared my testimony that it would be a minority report. I would like to preface what I say by the impression of what has gone on here in the last 3 hours.

I had a total misconception of health maintenance back in Wisconsin—I guess we do not get the message.

I think that the amendments proposed and spoken to by the other participants this morning, indeed, will maintain health, particularly the health of the insurance companies, the physicians and other providers. I do not think they will have much to do with the health of the American people.

With that preface, I would like to tell you a little about our experience in Marshfield with an HMO type operation for the last 5 years.

I wish to speak to—I said three items, but I am going to add one. I would like to address open enrollment, the community rating, and the unlimited contractual arrangements with the providers, and I would like to add that I wish to speak to the 51-percent rule as well.

I should put things in perspective by telling you a little bit about the atmosphere, environment of the Marshfield medical delivery system, the components of it, the Marshfield Clinic, St. Joseph's Hospital, and then deal briefly with our plan, our experience with open enrollment and community rating.

The clinic, as has been mentioned several times before, is a large clinic in rural Wisconsin. We provide tertiary care to a pretty large area of central and northern Wisconsin and peninsula of Michigan. We provide considerable secondary care to this area. We provide the only primary care to a population of approximately 50,000 people.

The clinic consists of physicians that are all salaried and who are a little bit unique in that all physicians at top salary—which they reach in 3 to 5 years—receive the same salary. I, as a surgeon, receive the same salary as a pediatrician, psychiatrist, internist, same as everybody else.

Senator KENNEDY. What is the fairness of that doctrine?

Dr. LAWTON. The fairness of it is very obvious to me, Senator.

People who come to Marshfield Clinic, and I operate on them, and take in many, many dollars, hundreds of thousands of dollars, are not coming to me—they are coming for medical care to the hardworking pediatrician, internists, psychiatrists, and there is no justice at all in my taking home the money because they happen to come to Marshfield Clinic.

The internist is available to me 24 hours a day, as is the pediatrician and all the other specialties. They are working as hard as I am.

By stroke of luck, I am in a high dollar producing specialty. It does not make me worth a nickel more to Marshfield Clinic. That has been our philosophy.

Senator KENNEDY. How did you develop that particular view?

It is obviously at very considerable sacrifice to yourself.

Dr. LAWTON. Yes, it is. I guess growing up in Wisconsin, we have a few funny ideas. Some of them come out here. It is related to my background, Senator.

I have been very socially conscious, and I have been exposed to many experiences in my lifetime that makes me feel that this is the way to do it.

Senator KENNEDY. A very admirable attitude.

Dr. LAWTON. We also have been innovative, in addition to the HMO, and we utilize physician assistants extensively, particularly in the surgery and primary care specialties; pediatrics, internal medicine, to a lesser degree. We have a school for physician assistants that we established 4 years ago. It graduates 15 to 20 primary physician assistants per year.

The hospital that we use is a sisters hospital, St. Joseph's Hospital, a modern 420-bed hospital. Incidentally, the sisters, I think, invented prepayment medicine. They, 80 years ago, offered to the lumberjacks for \$5 per year prepayment hospitalization for whatever period, and they had to be the earliest in the field of prepayment health delivery.

The hospital is a fine facility. The clinic has recently relocated its building to abut the hospital and share services. We have only one laboratory for both clinic and hospital; only one radiation therapy department, only one record room. We are sharing dietary services, sharing library services—we used to each have a large library. We now have one. The hospital is now building, and we will be able to share more services.

Regarding HMO plan, it had its origin in concept at least well over 10 years ago when myself and some of the other physicians started pushing to set up some type of prepaid plan, with not much enthusiasm from our colleagues. We were voted, or goosed, I guess you might better call it, by our then Congressman Mel Laird, who threatened us if we did not do something about the delivery system, he and some of his friends out here were going to.

We took him seriously and he was, at that time, enamored, as many people in Washington were and are, with the statistics from the Permanente-type group plan.

We pointed out to him these statistics really did not have much to do with the price of hay because they were based entirely, as we have heard this morning, on insuring groups with experience rating, healthy employed people, and did not and should not be applied to insuring the citizenry of the United States.

I am not sure we convinced him, but we did promise him that we would try to collect data that would be useful in designing national health or improvement in our health system.

A second motive in our setting up the plan was the nagging feeling on the part of several of us that while we were practicing the best medicine in the world, which we knew we were, we kept telling ourselves all the time that it was too expensive for many people in our community.

So, with those dual purposes, we launched into it.

We in Wisconsin have to have a carrier for such a plan. You cannot do it on your own.

We first talked to two commercial companies and one Blue. We talked for about a year and a half, in fact, and talked and talked and talked. And stumbled on the same issues that we have been hassling over here today. We were told repeatedly that you cannot have a plan with open enrollment. You cannot have a plan with enrollment without a medical exam. You cannot have a plan with community rating. And these talks just sort of succumbed to the dwindles because we insisted that this is what we wanted to do, these impossible requirements were unacceptable to them.

In late 1969, we were approached by Blue Cross of Wisconsin and Blue Shield of Milwaukee Surgical Care, who were willing to write the kind of plan that we insisted on.

The basics are simple. We provide the clinic and the hospital comprehensive total inpatient-outpatient coverage to a community defined by geography, a 15-mile radius around. There would be no deductible, there would be no coinsurance, there would be no preinsurance exams, there would be open enrollment twice a year.

I lost a battle on this. I thought it should be four times a year, but we have it in June and December.

In addition to that, the people who come into the plan are not identified to the physician. Our reasoning behind this was that we should not have either better or worse medical care.

As we boasted, we are practicing good medicine.

The second reason for this was at the time there were absolutely no statistics on the practice of fee-for-service medicine side by side with prepayment by the same physicians, and this data became available.

We have grown since March 1971 from a very modest 2,000 or 3,000 people into a present insured group of 31,000.

Some of the data quoted this morning was in error. We have 31,000 people. We are continuing to grow. We have monitored the system extensively.

There is a huge amount of data that has been made available to the committee. Mr. Nycz is available if you have questions. We have particularly monitored the group in nongroup experience throughout the 5 years.

The experience has shown us that open enrollment and community rating would not wipe us out. The plan has continued to grow.

Contrary to some of the testimony you heard this morning, we are competitive. We are competing with all the same insurance companies that these other fellows are, and yet we are growing. We are taking some of their contracts away from them, from groups, despite our rate, which is necessarily slightly higher. We are getting these people in because we provide more comprehensive care than the competing policies.

I cannot believe that in a defined community that these other fellows cannot do it, too.

If you restrict your community, and decide this is a community, give them a community rate and have open enrollment.

Today, in Marshfield, if you have a diagnosis of diabetes today, you can join our plan tomorrow. Or if you have a diagnosis of coronary heart disease today, you can join it tomorrow, because December is our open enrollment period. And this, I think is what we are talking about.

Are we going to continue insuring only those people who are not liable to be ill, or are we going to insure people who are potentially ill or are ill?

We do not accept people who are hospitalized at the time, but we accept people who have any sort of history of any kind of illness, and it has not wiped us out.

The other two issues I wish to address are the matter of the contractual arrangement with providers.

We have had modest experience in this expanding our plan beyond our 15-mile radius to two other hospitals on the periphery, 25 and 40 miles away. We have contracted on a fee-for-service basis with these providers.

Our experience is too short, too small, to say much about it, but I would point out that the reason for this amendment to allow this is quite obvious. It allows any medical society, foundation, insurance company, supermarket, to contract a fee-for-service basis with providers, and it is a propagation of what we are doing now.

The pitfalls in this approach are two. One is that by contracting willy-nilly, the provider is not at risk—you cannot capitate. There is no way for him to share the risk.

Second, I worry about quality control, if you have your physicians dispersed all over everywhere, not in a cohesive group, not tied together economically or medically, that quality control becomes very difficult, if not impossible.

I know that some plans have claimed that they can do it. I think it is a question whether it can be done effectively.

The 51 percent, the Marshfield Clinic has never applied for HMO certification, because we obviously would not qualify because probably 80 percent of our work is on non-HMO people. Eighty percent of our income is. And yet we are running an HMO side by side and within the group.

I would make a strong plea to abolish that 51-percent clause. There are a huge number of groups in the country who are the logical starting places for HMO's. They are established. They are growing.

If HMO's are going to succeed at all, it has to start with these. It boggles one's mind to figure out how you are going to start a medical group, which is a real can of worms, and start an HMO at the same time.

I would make a plea for that amendment.

I would conclude then that in our hands open enrollment has not been disastrous. It is, I feel, a very necessary part of any HMO. The same applies, of course, to community rating.

I might add that you cannot have community rating—well, a sample of the community—if all you had was healthy, employed persons, community rating deferred 5 years, it says in the amendment, is absurd, because, they will be no more able to have this 5 years from now than they are right now. They will fight it down to the wire. There will be reasons for not community rating at the end of the 5 years.

The other thing I should mention is that while our experience is 5 years, it was set up basically experimentally. We have not pursued all the alleged benefits of the HMO in our system. We do plan in the second phase to do so.

However, we have used physician assistants extensively. We have shared services instead of duplicating them. We have made an effort to keep down hospitalization in both our insured people and our fee-for-service people.

There are many other areas that we can improve, and particularly patient education. We have just hired a full-time patient educator, and this may point the way to telling us what preventive medicine is. We are not quite sure.

The other thing, several other people have mentioned here, and I would like to reemphasize, is that our experience certainly cannot and should not be applied willy-nilly to Los Angeles County or the United States of America.

What we have proven without a doubt is that a community can be defined and that you can have open enrollment and community rating. It is a matter of defining a community.

I am aghast at the amendments that passed the House. They have gutted the entire concept of HMO's. It has promoted and subsidized a continuation of our present unsatisfactory system of insuring only the well and letting the potentially ill fall by the wayside. This is known as shimming in the insurance market, I guess.

I do not believe that the Senate should promote a continuation of this totally unsatisfactory system. I would hope that you insist on open enrollment, community rating, and help these fellows write the definition of a community. That is the nut you have to crack.

It could be zip codes, geography, political boundaries, practice patterns. Where did they get their clients from before?

If you do that, it will work.

Thank you.

Senator KENNEDY. Excellent testimony.

Doctor, concerning this 51 percent, if that was varied or changed, how can you insure that the doctors are going to have a commitment to the HMO?

If we altered or changed that, what do you recommend we put in its place to try to assure that it does not go down to 5 percent?

Dr. LAWTON. I have not really thought about it, because I had not prepared testimony on it. I was requested by one of the consensus group, I guess that is the only thing we agree upon, to put in plea for this.

I think the percentage per se might be a little dangerous because of the wide variation and size of the groups.

I think a group, to effectively operate an HMO, has to have basic specialties, for instance, on board. We are talking about groups in the neighborhood of 20, but whether the same percentage should be applied to a group of 20 as to a group of 140, such as we have, I would have to think about it.

Senator KENNEDY. Could you give some thought to what ideas or suggestions you do have if we varied that percentage? How do you maintain the commitment to the HMO?

Dr. LAWTON. I would be glad to.

Senator KENNEDY. If you could just expand a little bit on how you are growing and a little bit about your competitive situation.

I am interested in how you are able to effectively compete and grow, and how you were able to do that.

Dr. LAWTON. We are competing obviously. We have never lost a group to another carrier.

We have taken a lot of contracts away. These are, a lot of them, small groups.

We have never had anybody move into our area to take advantage of the plan. It has never been documented. We are growing, I would say, because we are offering a better package.

While the price is a little higher, even employers will go with it because they know it is a better package.

Greg, what has our growth been each year?

Mr. NYCZ. I think we have managed to grow at around 30 percent per year.

In the original area that Dr. Lawton referred to, around approximately 15-mile radius, we have over 42 percent of every, say, warm body in that area participating in the prepaid program.

In the expanded geographic area, we have added on two additional counties, total population is around 97,000. We are getting close to one-third of that entire population participating.

Now, with the open enrollment provision, and then with marketing heavy to small groups, I think that is primarily where we are receiving a lot of our contracts.

However, if you take a look at the groups of 50 or more, these groups where they are supposedly—they are experience rated now—this is probably where the issue is, are we competitive in the big or larger employer groups, and we have got, I would say, close to one-third of all the groups of 50 or more participating in the program, which is about the same percent as the total.

I think it demonstrates we are competitive in the group business and in the larger group business. We are on something like 15 larger groups, and 9 of them are in on 100-percent basis, and the other 6 are on dual choice in which we have gotten over 50 percent under dual choice.

The premium right now is \$69.96 for a family, and if we were to take the other 30 groups that we have information on in the area and combine their premiums, an average, we would get around \$55.

We are about \$14 or \$15 higher on a family contract. Our marketing people tell us that in the situation where the employer pays 50 percent of the employee's premium, and they are approximately \$15 a month higher, they will get 50 percent of that group or better under dual choice.

It is because we run the program more efficiently. They do not have to worry about processing claims. There are many advantages.

Senator NELSON. Did you say \$14 higher?

Mr. NYCZ. That is \$14 higher than, say, an aggregate of the groups or our prospect type groups.

Dr. LAWTON. Those with indemnity plans in the area.

Senator NELSON. But the service provided is greater?

Mr. NYCZ. That is part of the reason, the fact that we are offering more comprehensive services.

Senator KENNEDY. On this point, do not others have deductibles in coinsurance?

Dr. LAWTON. Other plans we are competing against have a wide variety of benefits, and that was the point I was making, Senator.

While our premium is somewhat higher, nobody offers the comprehensive benefits that we do.

Senator KENNEDY. Don't they also have deductibles?

Dr. LAWTON. Very few of them pay very much for outpatient care, for instance.

Senator KENNEDY. On the area of deductibles and coinsurance, I have listened as long as I have been chairman of this subcommittee, about why we have to have deductibles and coinsurance, or otherwise we have vast overutilization of services, and I have yet to see how that has really been reflected in actuality.

I do not think people will go down to the doctor's office just for fun.

And with the Canadian experience, when they moved into their national program, it reflected that there was about a 5- to 6-percent increase, and most analysis of it showed that was in areas of need. Now, in terms of utilization, it is back to where it was before.

I would be interested in your experience.

Do you find there is overutilization?

Dr. LAWTON. There was greater fear at the outset, as I mentioned, we could not convince the insurance people to come into this without deductibles, there was fear on the part of physicians we would be deluged. People would be just coming to the doctor everyday.

I predicted, and I was right, that we did not change their medical habits very much. We do, in contrast to what you say, have people go to the doctors just for fun. But fee-for-service people do this, too. They do not change their habits that much.

But, very interestingly, since one of our purposes was to provide better medical care to the community, our data shows that our community, studying a group of patients who obtained their medical care at Marshfield Clinic a year before and then went into the plan, and studying them a year after, there is no question that there is a higher utilization at the outset of the plan.

But the important thing here, and it has been misinterpreted by many, and this was published in the New England Journal of Medicine, is that our people were substandard to begin with. This is not overutilization. They are coming up to the national average.

This whole matter of overutilization has got to be treated very gingerly.

What is overutilization?

In our group we have to throw out the statistics on physicians' family lists because they use so much.

Is this overutilization or is this just epitome of medical care?

My own feeling is that it is not a hazard at all.

To put a dollar barrier between people and going to the doctor is not the way to do it.

Senator KENNEDY. I have to leave.

I just want to thank you so much for coming. We are going to be asking for some additional data and statistics.

I want to thank you very much.

Senator NELSON. Mr. Nycz may be able to answer this.

Have you ever done a cost evaluation, comparing Marshfield's costs with another insurance plan's with less benefits? If you gave the same benefits as your competitors rather than greater benefits, would you be competitive on the dollar level?

In other words, you are giving more services, including outpatient, and obviously since there are more services, they cost more.

If you match their services, how do you evaluate your costs?

Mr. NYCZ. I think in that case the way the program is arranged, it is probably more efficient, it is probably run more efficiently than some of the indemnity type programs. So our administrative costs, overhead, are probably less.

So, for the same benefits, we are going to have a little bit of competitive edge there.

Senator NELSON. The statute did not require 51 percent. The statute required that members of the HMO be the principal professional activity of a group practice, and then the interpretation apparently of the Secretary was that it be 51 percent.

Do you see any hazards, any problems in allowing an HMO such as yours, in which about 20 percent of your patients are HMO, and 80 percent are not—do you see any hazards in what you have adopted in your clinic?

Dr. LAWTON. I tried to think about it before when Senator Kennedy asked the question.

I really do not see a hazard if the attractions for HMO are made sufficient, and I think this matter being able to offer it to an industry, for instance, and they have to look at it anyhow, is a very attractive thing for groups to get into HMO business. And I think they will be committee because they will expand their business.

Senator NELSON. I do not recall the reason for that. There is not any inherent value necessarily in 51 percent versus 25, or 60, or 80, is there?

Dr. LAWTON. No; but, as I mentioned, because of varying size of groups, I would be unwilling to say what would be a reasonable percentage.

Senator NELSON. You made reference to the fact that there are many clinics around the country already organized, and that it is difficult to put a group together.

I think it is your view that if this high 51 percentage were not required, a number of well-established clinics serving substantial areas now very well could establish a geographic area and have an HMO and have a mix of practice within it?

Dr. LAWTON. I think this is ideal. I think they are sitting there ready to go.

I think there should be something attractive enough about the bill and the amendment that they will want to go. I would predict that it can be kept that attractive.

I think the community could be defined, if they are not very brave, make it a small community. They give open enrollment to this community.

If they are more brave a couple of years later, apply for expansion of their community.

You cannot promise comprehensive medical services to people who are 80 miles away or 2 hours away in Los Angeles. You can provide it only to those that feasibly would obtain medical care at your installation.

Senator NELSON. I know you have a plane to catch and we have a rollcall underway.

[The prepared statement of Dr. Lawton follows:]

MARSHFIELD CLINIC
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STATEMENT OF
BEN R. LAWTON, M. D., PRESIDENT
MARSHFIELD CLINIC
BEFORE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR
AND PUBLIC WELFARE
U.S. SENATE
ON
AMENDMENTS TO THE HEALTH MAINTENANCE
ORGANIZATION ACT OF 1973

Mr. Chairman and Members of the Subcommittee, I am pleased to appear here today to present what probably represents a minority position in these hearings regarding the amendments to the Health Maintenance Organization (HMO) Act of 1973.

I am President of the Marshfield Clinic, a multi-specialty group of 140 physicians in central, rural Wisconsin. We have been involved in an HMO type operation for the past five years. It is on this experience that I base my testimony.

I wish to address three aspects of the proposed amendments. First, the abolition of the open enrollment requirement. Secondly, the abandonment of the community rating requirement. And thirdly, the section which permits unlimited contractual arrangements with providers.

DESCRIPTION AND HISTORY OF THE MARSHFIELD CLINIC AND ST. JOSEPH'S HOSPITAL

I should first put things in perspective by describing our local medical delivery system and the history of our health plan.

The Marshfield Clinic is a 60-year-old, 140-physician, multi-specialty group located in Marshfield, Wisconsin, a city of 16,000 people. We provide tertiary care and much secondary care to a large area of central and northern Wisconsin as well as the upper peninsula of Michigan. We provide the only primary care to a population of approximately 50,000 people. All the physicians in the Marshfield Clinic are salaried; in fact we are somewhat unique in that all specialists receive the same salary when at top pay. We have utilized physician's assistants extensively since 1967, especially in surgical specialties and to a lesser degree in primary care--pediatrics and internal medicine. We initiated in 1972 and continue to operate a physician's assistant school which graduates 15-20 primary physician's assistants per year. We have grown from 22 doctors in 1954, when I joined the group, to 140 physicians today in response to demand for our services.

We utilize St. Joseph's Hospital and constitute almost its entire staff. The hospital is a modern, 420-bed facility, operated by the Sisters of the Sorrowful Mother who probably invented prepayment 80 years ago when they furnished total hospital care to the lumberjacks for \$5.00 per year on a prepayment basis. We have recently relocated our clinic to be physically attached to the hospital where we share

many services. We have only one laboratory for the clinic and hospital. We have only one radiation therapy department. We share dietary, laundry, medical record and library services. With additions to the hospital now in progress many other services can be shared instead of duplicated.

HISTORY AND DESCRIPTION OF THE GREATER MARSHFIELD COMMUNITY HEALTH PLAN

The Greater Marshfield Community Health Plan had its origin and concept at least 10 years ago when several of us began pushing for a prepayment plan with little enthusiasm generated on the part of our colleagues. We were convinced (and told everyone including ourselves) that we were practicing the best in medicine, but there was the nagging feeling that there were many in our community that couldn't afford it.

In 1968 we were goaded by our then Congressman Melvin Laird to do something, or he and his friends in Congress would. He and others out here were enamored with the statistics from Permanente-type groups and saw no reason that these methods and results could not be applied to the delivery system in general in the United States. We pointed out that the reported experience was strictly with groups and experience rated with no open enrollment and hardly applicable to a community.

We therefore proposed to start a prepayment plan for two reasons. First, to extend our services to the entire community and, secondly, to gather some meaningful data on such a plan that might be useful to the government and to others.

In Wisconsin we are required by law to engage an insurance carrier for such a venture. We initiated discussions with two commercial carriers and one Blue Shield carrier. We talked, and talked, and talked for one and a half years but always wound up stumbling on the same issues that we address today. We were told repeatedly that you cannot

survive in the market if you have open enrollment without medical examination, and you cannot survive in the market with community rating or without deductibles or co-insurance. These talks succumbed to the dwindles because we insisted on all of these impossible requirements.

In late 1969 we were approached by Blue Cross of Wisconsin and Surgical Care-Blue Shield of Milwaukee who were willing to write exactly the kind of a plan we wanted. The basics were simple. We (the Clinic) and St. Joseph's Hospital would provide comprehensive health services to a geographically defined population with no deductibles, no co-insurance, no pre-existing illness clauses, with open enrollment for four weeks twice a year, and with community rating. It was further specified that the people in the plan would not be identified to the physician. We felt that the people in the plan deserved no better or worse care than our fee-for-service patients. Furthermore, we could in this manner gather comparative statistics on the prepayment plan running side-by-side with fee-for-service by the same physicians.

I would be amiss to imply that the discussions leading to the final design of the plan were simple. They were not. They were eyeball to eyeball for over a year, but I must credit Blue Cross of Wisconsin and Surgical Care-Blue Shield of Milwaukee, along with St. Joseph's Hospital with the utmost cooperation in maintaining the original goals of providing comprehensive health care to the community and gathering data that would be useful in evaluation of this method of financing health care.

We launched the plan in March of 1971 and therefore have almost five years experience. We have grown steadily, now insuring 31,000 people. This represents 42% of our original geographic area or 33% of our recently expanded geographic area. We have had a modest experience in contracting with physicians and hospitals in two neighboring communities, 25 and 40 miles away to expand the scope of our coverage.

EXPERIENCE DATA WITH OPEN ENROLLMENT AND COMMUNITY RATING

We have monitored our experience extensively and there is a huge amount of information still stored in the computer but not analyzed. We have, however, examined the policies of open enrollment and community rating in depth and continuously. I have submitted the detailed supporting material, and our data analyst accompanies me if there are questions. I will review only the highlights.

We have been operational with open enrollment and community rating for five years. If today you have a diagnosis of diabetes or coronary heart disease in Marshfield, tomorrow you can enroll in our plan because this is our December open enrollment period and this is what we are talking about. Are we going to continue to insure only the employed, healthy person or shall we also insure the person who might become ill? This policy has not wiped us out. Our competitors in the health insurance field have launched vigorous campaigns to counter our effort. We have continued to grow. We have never been able to document a case where a family moved to our area to take advantage of our plan. We have never lost a group contract to competing plans. We are competitive. Open enrollment participants are indeed higher utilizers than our group enrollees. Open enrollment people have consistently constituted 24-26% of our entire insured population. They utilize 26-27% of the outpatient visits but significantly they utilize 33% of hospitalization days. However, this figure has not changed appreciably over the five years; in fact utilization has lessened somewhat and we must conclude that a small group of potentially sick people will enroll with open enrollment as we hoped they would. But this small sub-group is being balanced by the group enrollment and by the healthy open enrollment people. They are not all basket cases.

Detailed analysis of our cost data shows that the group enrollees subsidize the non-group (or open enrollees) by approximately \$1.00 per person per month on their premium. I submit that this is one of the basic concepts of an HMO--that the walking well should in some degree subsidize the potentially ill.

CONTRACTUAL ARRANGEMENTS WITH PROVIDERS

The third matter which I wish to address is that of the unlimited permissiveness of contractual arrangements with providers. We have had only very modest experience in this field in expanding our plan beyond the original 15-mile radius.

I am fully aware of the motives for this amendment. It allows any medical society, pseudo-foundation or local supermarket to declare itself an HMO and contract on a fee-for-service basis with providers. I think there are real hazards in this concept. In the first place there is no real good way to accomplish capitation and therefore risk sharing by the provider. Secondly, it poses very difficult problems in quality control if the providers are widely dispersed and do not constitute an organized group. Our own experience is too limited and short to supply meaningful data but I would be very uneasy about applying this principle on a broad scale across the country.

CONCLUSIONS AND RECOMMENDATIONS

In conclusion, I would contend that open enrollment and community rating are absolutely essential parts of an HMO experiment. Secondly, these policies are not disastrous in the competitive field if a community is defined. Lastly, I believe that unlimited contractual arrangements with providers are fraught with potential pitfalls.

I would emphasize that since our plan was essentially experimental that we have not developed to the fullest extent the alleged benefits of an HMO operation. We have utilized physician's assistants to a high degree. We have made every effort to decrease hospital utilization, not only in these patients but in our fee-for-service patients. We have made every effort with the hospital to share rather than duplicate facilities. We, as others, have been unable to get a handle on what really constitutes preventive medicine. We have only recently employed a full-time patient educator, which may help point the way here.

I would further caution that our experience is that of almost a monopoly in a rural area and cannot and should not be applied willy-nilly to Los Angeles County or the United States of America. However, we have proved beyond doubt that if the community is defined that open enrollment and community rating are desirable, necessary, and financially feasible components of any HMO operation.

I am most distressed by the amendments passed in the House. I think they have gutted the entire concept of HMO's. The deferment of five years for community rating is absurd. There is no reason to expect that an HMO will be better able to community rate in five years than they are now if they have never had open enrollment to insure the community. I think the House has caved in to special interests to the point of promoting a continuation of our present unsatisfactory system of insuring only those people who are least likely to become ill. I believe this is known as "skimming" in the insurance industry. I would prefer that no amendments be made rather than accept this total retreat from the basic concept of HMO's.

I would hope that the Senate would insist on open enrollment and community rating with a simple definition of a community by whatever means--geography, zip codes, political boundaries or pre-existing practice patterns.

I would be happy to answer any questions that members of the Committee may have.

STATEMENT OF PURPOSE
AND
GUIDELINES FOR OPERATION
OF THE COMMUNITY COMMITTEE OF THE
GREATER MARSHFIELD COMMUNITY HEALTH PLAN

WHEREAS, health care is generally regarded as a right for all Americans; and

WHEREAS, there is a mounting public and professional concern over the health care problems that confront our nation; and

WHEREAS, escalating cost, maldistribution of resources, uneven quality of care, apparent manpower shortages, obsolete financing patterns and obsolescent organizational and physical structures are well recognized in the health field; and

WHEREAS, there has been established in the Greater Marshfield Area a Pre-Paid Group Practice Plan called the "Greater Marshfield Community Health Plan"; and

WHEREAS, said Pre-Paid Group Practice Plan was created by:

(a) Pre-paid Group Practice Group Master Contract between the Associated Hospital Service, Inc., Surgical Care Blue Shield Plan of the Medical Society of Milwaukee, County and Employer Groups and Direct Pay Subscribers;

(b) Medical Service Agreement, dated January 1, 1971, Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County, and the Marshfield Clinic;

(c) Pre-paid Group Practice Plan Hospital Service Agreement-Associated Hospital Service, Inc. and St. Joseph Hospital of Marshfield, Wisconsin, Inc.

WHEREAS, it is believed that the Pre-Paid Group Practice concept best succeed in the Greater Marshfield Area with active community leadership; and

WHEREAS, the sponsoring organizations have requested that there be formed because of the concern for the health care problems facing the Greater Marshfield area, a Community Committee of the Greater Marshfield Community Health Plan.

WHEREAS, in order for the Community Committee to properly perform its functions, it is necessary that it adopt a Statement of Purpose and Guidelines for Operation.

NOW, THEREFORE, said Community Committee does hereby adopt the

following:

ARTICLE I.

Definitions.

When used herein, the term "sponsoring organizations" shall intend to mean the Marshfield Clinic, St. Joseph's Hospital of Marshfield, Inc., Associated Hospital Service, Inc., Wisconsin Blue Cross Plan and Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County.

ARTICLE II.

Purposes.

The purposes of the Community Committee:

- 1.) Provide local community direction, support, and responsiveness to needs of sponsoring organizations.
- 2.) React to and recommend changes in policy to the sponsoring organizations.
- 3.) Concerned with extension of benefits.
- 4.) Review and recommend on the Plan's financial matters including rates.
- 5.) Provide educational campaigns to avoid over or under use.
- 6.) Liaison with other similar organizations in the State.
- 7.) Review reports concerned with performance of Plan.
- 8.) Evaluate Plan through questionnaire to participants.
- 9.) Provide newsletters and Speaker's Bureau for Communicating to participants.
- 10.) Talk with and help get support of government agencies to participate in the Plan
- 11.) Provide sounding board for patients and others.
- 12.) Aid in determining enrollment periods and qualifications.
- 13.) Be concerned with new equipment and new use of medical personnel.

ARTICLE III.

Membership.

Section 1. General. The Committee shall be composed of from Ten (10) to Twenty (20) adult citizen members as determined from

time to time by the Committee. A majority of the citizen members shall be participants of the Plan and all members shall reside in the service area of the Plan and be representative of the service area on a proportional basis. Membership shall also be representative with the participant enrollment, taking into consideration industry, business, labor, governmental units, health and welfare participants, if any, and others. It is intended that no rigid pattern for membership be required and that membership can be varied to assure necessary and effective Committee membership.

SECTION 2. Admission to Membership. The initial membership of the Committee shall consist of the following:

Mrs. Leland Brunker, Colby, Wisconsin
 Mr. Henry Bluhm, Marshfield, Wisconsin
 Mr. Patrick Felker, Marshfield, Wisconsin
 Rev. William Grevatch, Marshfield, Wisconsin
 Mrs. Dena Hayden, Marshfield, Wisconsin
 Mr. Philip Hein, Stratford, Wisconsin
 Rev. James A. Kaestner, Marshfield, Wisconsin
 Dr. Norbert Koopman, Marshfield, Wisconsin
 Mr. Carl L. Meissner, Marshfield, Wisconsin
 Mr. Donald Pernsteiner, Stratford, Wisconsin
 Mr. Edmond Smith, Marshfield, Wisconsin,

and shall serve until the monthly meeting in January of the year following the approving and adopting of these Guidelines. Thereafter, one-half of the members of the Committee shall be elected each year at the January meeting. Each Committee member shall serve for Two (2) years or until their successors are elected and qualified. Vacancies in the Committee shall be filled by appointment by the remaining Committee members and members so appointed shall serve until the next January meeting of the members at which time a member shall be elected to fill the unexpired term. Except for members of the Committee who are in office at the effective date of these Guidelines, no member of the Committee shall hold office for more than Two (2) consecutive terms.

Membership of the Committee, after the initial membership shall be determined by and voted on by the Committee members, from a list of nominees submitted to the Committee by participants of the Plan. The Committee shall take into consideration the general requirements as set forth in Section (1) hereof and to encourage participants in the Plan to make recommendations to the Committee members prior to voting on said Committee members, the Committee shall submit to the sponsoring organizations for review and consideration, the list of the nominees.

Members of the Committee shall serve without compensation, however, reasonable and appropriate expenses incurred for Community Committee activities will be reimbursed by the sponsoring organizations.

ARTICLE IV.

Meeting of Members.

SECTION 1. Regular meetings of the Committee shall be held monthly at such time and place as the Committee may determine.

SECTION 2. Special meetings of the Committee may be called at anytime by the Chairman.

SECTION 3. Notice of a special meeting shall be given by the Chairman in writing delivered or mailed not less than Five (5) days nor more than Fifteen (15) days before the meeting, excluding the day of the meeting.

SECTION 4. A quorum of any meeting shall consist of a majority of the members of the Committee.

SECTION 5. The sponsoring organizations shall provide meeting places for the Committee in the Clinic or Hospital or other suitable facilities.

SECTION 6. Sponsoring organizations shall provide the Committee with the necessary information related to questions before the Committee. It may be necessary for the sponsoring organizations to make studies and to organize and present information to the Committee to assist in carrying out its functions.

ARTICLE V.

Voting.

Each member shall be entitled to cast One (1) vote on each question presented. Any such question shall be decided by a majority of the votes so cast, provided there is a quorum. Proxy voting shall be prohibited.

ARTICLE VI.

Officers.

SECTION 1. The officers to be elected by and from the members of the Committee shall consist of the Chairman, Vice-Chairman and Secretary-Treasurer. The officers shall be elected by written ballot by and from the members of the Committee at the January meeting, and shall hold office for a One (1) year term or until their successors are elected and qualified.

SECTION 2. The Chairman shall preside at all meetings of the members. He shall appoint all Committees, sign all Agreements and documents as required and have such other powers and perform such other duties as the Committee may determine.

SECTION 3. The Vice-Chairman shall, in turn, perform the duties and powers of the Chairman in the absence or disability of the Chairman.

SECTION 4. The Secretary-Treasurer shall keep all minutes of the meeting of the members, shall keep all books, records, and instruments belonging to the Committee, together with the Chairman, sign all Agreements, instruments and documents as may be required, safely keep all money, property and other things of value belonging to the Committee, and systematically keep financial records and make reports of the financial standing of the Committee to the members of the Committee as may be required.

ARTICLE VII.

Committees.

For the better execution of their powers and duties, the Committee shall appoint from its members, such Sub-Committees as occasion may require and as they deem necessary. Such Sub-Committees shall serve for One (1) year or until their successors are appointed. The Committee shall define the duties of each Sub-Committee.

ARTICLE VIII.

Amendments.

These Guidelines may be altered, amended or repealed and new Guidelines may be adopted by the Committee at any regular or special meeting by the affirmative votes of at least Two-thirds (2/3) of the total number of members of the Committee and with the approval of the sponsoring organizations.

The foregoing Guidelines were adopted at a meeting of the members of the Community Committee of the Greater Marshfield Community Health Plan here in the City of Marshfield, Wisconsin, on the _____ day of _____, 1973, by unanimous vote of the members then and there present.

COMMUNITY COMMITTEE

By: _____

APPROVED:

ASSOCIATED HOSPITAL SERVICE, INC.
The Wisconsin Blue Cross Plan

By: _____

SURGICAL CARE, The Blue Shield Plan
of the Medical Society of Milwaukee
County

By: _____

MARSHFIELD CLINIC

By: _____

ST. JOSEPH HOSPITAL OF MARSHFIELD,
WISCONSIN, INC.

By: _____

SPECIAL

The Greater Marshfield Community Health Plan—A Community Experiment

RUSSELL F. LEWIS, MD
Marshfield, Wisconsin

ON MARCH 1, 1971, the first group of participants started receiving health care under the Greater Marshfield Community Health Plan (GMCHP), a prepaid medical care program jointly sponsored by the Marshfield Clinic, St. Joseph's Hospital, and Wisconsin Blue Cross and Surgical Care Blue Shield of Milwaukee. Approximately one year of negotiation went into preparation of the plan.

Our initial interest was stimulated by a strong belief that public opinion was forcing the federal government to establish new pathways for accessibility of care and to attempt control of the increasing cost of medical care. We believed that most prepaid programs, health maintenance organizations, and other proposed solutions did not meet what the American public is demanding, namely, total comprehensive health care at reasonable cost to every citizen regardless of income, geographic location, or state of health.

Our first objective was to establish the cost of high quality medical care in this type of program in rural Wisconsin, not to determine whether this was a better means of delivering health care services. Our second objective was to try making the same comprehensive care available to all citizens within our area. This report is intended to outline what the Greater Marshfield Community Health Plan is, give some historical background, report some of our findings during the first 16 months of operation, and comment on our changing philosophies and objectives.

Background

Central Wisconsin physicians were encouraged in January 1968 by (at that time) Congressman Melvin R. Laird, ranking Republican member of the Health Subcommittee of the House Appropriations

Committee, to do something positive to meet health care problems. Mr. Laird contended that public pressure was so great that Congress would be compelled to enact sweeping health reform measures, probably by 1972 but certainly no later than 1975. He and we were concerned that background information being utilized in Washington had been accumulated primarily from the Kaiser, HIP, and other plans, the only sources of adequate statistical data. However, we felt that these groups were selective and not representative of the population area they served. This and other factors caused us to question whether the statistics were meaningful in our context.

Our interest led to meetings with two Wisconsin companies in our area, Employers Mutual Insurance Company of Wausau and Sentry Insurance Company of Stevens Point, to discuss proposals that would provide the entire population of our area with an acceptable comprehensive plan. Later, Wisconsin Physicians Service (WPS Blue Shield) joined the discussions. Originally we involved the physicians from Marshfield, Wisconsin Rapids, Stevens Point, and Wausau. After a series of meetings and a trip to Washington, the Department of Health, Education, and Welfare suggested a survey in our area, and the Comprehensive Health Planning group was selected. Meanwhile, the Office of Economic Opportunity (OEO) asked to be involved in the survey. This was cleared with Washington and, in the summer of 1968, OEO canvassed households in five Central Wisconsin counties. The survey was done by the National Opinion Research Corporation of Chicago and, although it was concluded in late 1968, the data became available to us in late 1969. The original HEW survey was contracted to the Rosenfeld firm of New York and was completed in early 1971. Both studies involved the same five counties but were totally different in scope.

During the latter half of 1968 and most of 1969, it became apparent that we were just talking about a better insurance program at a higher premium. We physicians were still insisting on fee for service and free choice of physician. This made innovation difficult and, despite efforts of the insurance companies and some of the physicians, the program lacked sufficient stimulus to keep going.

About three years ago officials of the Wisconsin Blue Cross volunteered their concern about the impact of Kennedy-type proposals in Washington. They realized the necessity for the private sector, represented by groups like theirs, to prove their value in the health-care field or, perhaps go out of existence. They suggested an experimental prepaid program to

From the Marshfield Clinic, Marshfield, Wisconsin.

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prove their capabilities and to obtain some experience. Because no other physicians practice in Marshfield, we Clinic physicians believed that we could retain our original objectives and yet conduct a meaningful experiment without creating a problem of competition.

The Marshfield Clinic at that time was a multi-specialty group of 102 physicians representing virtually all specialties and having had a salary philosophy of equal distribution since 1954. Located in rural central Wisconsin, the city of Marshfield is a community of 15,800 people having a slow but steady growth. We are fortunate to have St. Joseph's Hospital, a well equipped modern facility with 416 beds. Only three active physicians on the Hospital staff are not members of the Clinic. They are based in Colby, a town of 1,500 people 20 miles from Marshfield. The Marshfield Clinic receives referrals from much of northern Wisconsin and upper Michigan. The population within a 15-mile radius of Marshfield is about 35,000, contributes about 20% of total Clinic income and represents a minimal risk, even if a large number should enroll in the plan.

Establishing the Plan

The program was designed to provide total coverage for every person enrolled. Wisconsin Blue Cross and Surgical Care Blue Shield accepted our ideas even though they were not always actuarially sound. The rate structure was developed jointly and was limited by what the insurance company deemed was marketable. We attempted to avoid the "catches" and exclusions so familiar to patient and doctor alike in the average insurance plan. We insisted that we try to enroll the entire population rather than just predictably healthy and productive people.

We believed the coverage adequate but considered the cost out of reach of most families having incomes less than \$8,000 a year. To help such families, we went to Washington and proposed an experimental federal subsidy on a sliding scale to support the economically disadvantaged. Thanks to help from Dr. Paul Ellwood, who had just originated the health maintenance organization (HMO) concept, our reception was cordial but, in the absence of specific legislation, received no funding.

A second visit in September resulted in more concrete suggestions, and we began to formulate the specific information requested. By the time this was completed, the people in Washington had been transferred; and we decided that we in Marshfield had neither the capability nor the time to do what was necessary to obtain federal aid. Therefore, we employed a consulting firm that chose to approach OEO. Unfortunately, our proposal was not accepted.

Since that time we have been very fortunate in

securing a grant from the Family Health Center Program in HEW to which we applied in April 1972. In June, we were awarded slightly more than \$500,000, renewable each year for three years, to help subsidize on a sliding scale those families with annual incomes of less than \$7,000. Currently we are trying to arrange the details and implement this program as an integral part of the Greater Marshfield Community Health Plan.

The Plan

Provisions of the Greater Marshfield Community Health Plan:

1. All outpatient Clinic services in full including equipment, medication, supplies, and professional services rendered by physicians and paramedical personnel;
2. Full outpatient Hospital services and 365 consecutive days of inpatient Hospital care per admission including full allowance for semi-private room and 100% of all miscellaneous Hospital services;
3. Care in an approved skilled nursing facility for convalescent and long-term illness, if such services will contribute to the participant's recovery from the condition, disease, or ailment responsible for the hospitalization;
4. Services provided by home-visiting nurses under the direction of Clinic physicians;
5. Emergency out-of-area care in full at reasonable and customary charges;
6. Specialized care not available from the Clinic or Hospital if such care is deemed necessary by a Clinic physician and is based on direct referral from him;
7. Psychiatric care for up to 70 days per period of disability in Hospital, up to 10 Clinic visits for each period of disability, and renewal of coverage after 90 days;
8. Coverage from birth until marriage through the calendar year of age 19 or, if full-time students, through the calendar year of age 25; and
9. Coverage of totally and permanently disabled dependents without age limit.

Exclusions of the Greater Marshfield Community Health Plan:

1. Dental services other than those provided by the Clinic's oral surgeons;
2. Outpatient drugs;
3. Services covered by Workmen's Compensation of Employer Liability Law;
4. Care of tuberculosis after diagnosis;
5. Services of blood donor and blood plasma;
6. Services provided or available under government law;

7. Eye glasses, artificial limbs, and cosmetic surgery (except for trauma or birth defects);
8. Ambulance service;
9. Some examinations for employment, insurance coverage, and the like; and
10. Care rendered by an optometrist or podiatrist outside of the Clinic.

During the first enrollment, all waiting provisions were waived. During the second enrollment, from November 1 to January 1, 1972, a wait of 270 days for maternity care was in effect except in the case of prematurity or existing maternity coverage by another group plan.

Financial Aspects of the Plan

Originally the Clinic received \$4.86 as monthly capitation for each participant. The Hospital preferred an allowance per diem for inpatient care and compensation for care in the emergency room. Funds were allocated for out-of-area hospital and physician services at the usual and customary fees for illness or accident outside of our service area. Provision also was made for referral of patients out of the area for services not available in Marshfield. Blue Cross received administrative expenses and budgeted equal amounts for marketing and administration. These were the Plan's original allocations:

Clinic -----	\$ 4.86
Hospital -----	\$ 6.65*
Blue Cross -----	\$ 1.00
Out-of-Area Services --	\$.69
Referred Out-of-Area --	\$.26

Total -----) \$13.46 per person

* Equivalent to \$71 per day plus emergency room charges

The average family size in our area is 3.7 individuals and this multiplied by \$13.46 yielded a monthly premium of \$49.80 per family. The individual monthly premium was arbitrarily set at \$17, too low in retrospect. The Hospital subcontracted for nursing-home care (excluding custodial care) on a 2:1 basis and home-nursing service on a 5:1 basis.

Initially we decided that, if we did not utilize the calculated hospital services, the surplus would be applied to any loss sustained by any partner. Surpluses beyond that would be divided 50% to the Clinic, 25% to St. Joseph's Hospital, and 25% to Blue Cross/Blue Shield. The latter would use their portion of surplus to recover their expense of the developmental program. Any excess beyond that would stay within the community or the Plan. If the money obtained from the original contract did not cover

rendered services, it was agreed contractually that this could be recovered in later years.

Enrollees

The first group, about 1500, was the Marshfield Clinic physicians and employees and their families who joined March 1, 1971. St. Joseph's Hospital employees and families, about 1600, became members April 1. Open enrollment lasted until July 1, 1971, during which time a sincere effort was made by Blue Cross to contact all groups and every person within the selected geographic area. Anyone under 65 could join if he could pay the premium. There were no waivers or exclusions for pre-existing conditions. The second open enrollment lasted from November 1, 1971, to January 1, 1972. Enrollment is closed periodically to prevent individuals from delaying enrollment until illness occurs. The third open enrollment lasted from May 1, 1972, to July 1, 1972.

Some Features of the Plan

First dollar coverage; no deductibles. This was based on previous experience convincing us that deductibles would have to be substantial before they would affect the utilization. In our experience, people in our area do not like to come to the Clinic or Hospital unnecessarily, so we started with only minor worries about over-utilization. Also, in our experience, cost of collecting deductibles made their use unfeasible.

Free choice of physician within the Clinic and the area. Patients calling or coming to the Clinic for an appointment were handled just as they had been before the Plan. This meant free choice of physician. One of our first and most important experiences reaffirmed our fundamental belief that patients want free choice. This is illustrated by the community of Spencer and farm areas between Marshfield and Colby where a three-man group has a large office practice and is on the St. Joseph's Hospital active medical staff. Many people preferred the Colby Clinic for their primary care but came to the Marshfield Clinic for what they considered more complicated medical needs. As originally outlined, the Plan would not have allowed them to utilize the Colby Clinic without paying separate fees for service. Because of our long-standing association with these physicians, it seemed simpler to reimburse them on a fee-for-service basis using their usual and customary charges.

This procedure was adopted and subscribers now have a choice between the Marshfield Clinic and the Colby Clinic. Once a month the Colby Clinic bills the Marshfield Clinic for services rendered

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and is paid out of the capitation received by the Marshfield Clinic. Since that time we have made a similar agreement with Dr. Frederick Kroepin, a general practitioner with an office practice in Stratford, and with Dr. Robert Capling, an osteopathic physician with an office practice in Pittsville, 17 miles south of Marshfield. These men have been on the hospital courtesy staff for some time. On July 1, 1972, Dr. Morgan Ellis, an osteopathic physician from Abbotsford, 22 miles north of Marshfield, joined the Plan, slightly expanding our geographic area.

"Anonymity" of patient. We have studiously avoided any method of conveying a patient's method of payment to the physician. Unless the patient reveals this or the physician happens to know the patient works at the Hospital or the Clinic, the physician does not know the patient's method of payment. We have stressed this because we did not want to alter the pattern of care, nor did we want to be accused of giving second-class medicine to any member of the Plan. We have made no effort to send patients to any specific physicians or to use physician assistants.

Community participation. At the suggestion of Blue Cross, a Community Committee was established once the Plan got underway. They were told that they were not to be a rubber stamp but were to advise actively. To date, after spending a good deal of time getting acquainted with the plan, deciding objectives of the Committee, establishing by-laws, and the like, they have made some excellent contributions including the shaping of some of our philosophies. We anticipate a much more important role by the Committee as we start adding other services, public relations, and the like. Currently the Committee is chaired by Dr. Norbert E. Koopman, Dean of the University of Wisconsin Center (in Marshfield) and consists of representatives from the clergy, industry, labor, farming, small communities, government agencies, and others.

Special Groups

Title 19. The State Department of Industry, Labor and Human Relations has expressed a willingness to participate in an experimental program. However, Wisconsin law forbids payment for services before they are rendered. A modification of this law was proposed in the 1972 Legislature. No one opposed it, and we anticipate passage in the 1973 session.

Title 18—Medicare. We chose to wait for passage of HR-1 and expect now to actively pursue incorporating this group in the Plan.

"The near poor." Our major disappointment to date has been failure to make the program available

to people who cannot afford to enroll. As mentioned previously, the Family Health Center has just granted funds to help those people not on welfare (Title 19) but whose family incomes are \$7,000 or less a year. These federal funds will pay a portion of the premium on a sliding scale. At present we are negotiating to enroll this group as regular members of the Plan so that they will receive exactly the same benefits and same care as any other Plan member. This will require a waiver in the grant, but we are optimistic. An estimated 3,000 to 5,000 individuals are in this group.

Plans for Expansion

When the program started we wanted to keep the geographic area well defined. Addition of physicians in the area did cause minimal expansion. Some participants living 35 miles from Marshfield are enrolled in the Plan through group plans of employers. Apparently some of these people have shifted their medical base from local family physicians to the Clinic in order to enjoy the financial advantage. As a result, we have discussed methods of solving this problem with some of the physicians in the nearby communities. Basically, however, we still believe that the Marshfield Clinic cannot offer primary care to people living more than 20 to 25 miles away.

Results

Financial. During the first 16 months of operation from March 1, 1971 through June 30, 1972, the Marshfield Clinic's contingent liability or loss was more than \$409,000 and St. Joseph's Hospital's more than \$73,000. The Clinic and Hospital loss represents the cost of delivering the care plus 4%, a concept established at the start. Had the physicians received fee-for-service for services rendered, the contingent liability would have been slightly more than \$500,000. We attempted to make this figure accurate by considering uncollectable debts, reduction in administrative paper work, and the like, and discounted a considerable sum for over-utilization on the part of Clinic physicians, their families, Clinic employees, and their families. These first 16 months reestablished the fact that physicians and Clinic employees utilize medical services more than anyone else. Before the Greater Marshfield Community Health Plan, these services were free.

Because the original calculation for hospitalization was based on 0.825 days annually per person and the actual utilization was 0.732, some excess money accumulated. In addition, the out-of-area and referred-out-of-area services were less than those budgeted. These surpluses plus accumulated interest totaled about \$170,000 from which the Clinic will receive about \$130,000. This means that the Marsh-

field Clinic lost about \$280,000 in the first 16 months. Why?

1. Obvious errors in the original calculation based on previous experience, during which time the costs of medical care increased rapidly.
2. An error in judgment by some of us physicians who publicly discussed the Plan. A family of two was enrolled for \$34 (two single memberships) because this seemed logical. By the time the insurance company told us that this was not financially feasible, we felt morally committed. Blue Cross estimated that this commitment cost us approximately \$108,000 during the first year of operation.
3. Enrolling anyone with a medical problem. The Plan appealed to those individuals who were sick or had large anticipated medical costs. However, despite rumors, people have not moved to Marshfield to take advantage of the Plan.
4. Large families in the Plan. The premium was based on a family size of 3.7 members per family when, in fact, the size is 4.9. This did not include the two-member families enrolled as two singles.
5. The Plan's experimental nature. No effort was made to contain costs because we wanted data to establish the maximum sum currently required for care of the greatest-risk group in our area, at least among those who could afford the premium.
6. Marshfield's typical, rural, midwest conservatism. Many groups and small industries, unions, and the like adopted the attitude of wait and see. Also, union contracts often run for two and three years, so these larger organizations with healthier people were unable to enroll initially.

Utilization

To date the computer has cumulated much information, the significance and evaluation of which are being studied by Dr. John Mitchell. We expected increased utilization in the Plan because some of the subscribers were ill from the start. Perhaps for this reason physicians did not subjectively feel that patients were over-utilizing the Plan. We divide our participants into four major groups.

1. Clinic physicians and employees.
2. Hospital employees.
3. Group participants.
4. Non-group participants (individuals who purchased their own insurance).

The Clinic group utilizes our services at a higher rate than the others. As might be expected, the non-group members are second. Many of these have been unable to get other health insurance because of pre-existing conditions, often serious, and have taken advantage of open enrollment periods to enroll. Third in utilization are the Hospital employees, and last are the members of groups.

If the Clinic's patients were grouped by method of payment, initial data seem to indicate the greatest use of outpatient facilities by Medicare patients, next by Medicaid patients, next by Greater Marshfield Community Health participants, and least by fee-for-service patients. The latter group includes those not insured as well as those in other insurance programs.

Hospital utilization has already been mentioned. It did not change materially during the first year of the Plan. Before the Plan, the state rate quoted by Blue Cross was 1.1 days annually per person. In the general area of the Plan, it was 0.825, and somewhat less in Marshfield. GMCHP participants utilized the hospital during the first 16 months at a rate of 0.732 days per person per year. The physicians and hospital made no effort to reduce hospitalization during this time.

Compared with patients not enrolled in the Plan, departmental utilization based on percentage of total fees showed only a few minor variations. Radiology and the laboratory provided 15% and 14% of services respectively, on either basis. Perhaps, the most striking feature was in Oral Surgery which represented 6% of Plan services, but less than 2% of fee-for-service. Both Pediatrics and Obstetrics/Gynecology showed slightly higher usage by Plan participants as anticipated. Cardiovascular and Thoracic Surgery represented a dramatically greater percentage of fee-for-service patients as would be expected due to the referral nature of this type of problem.

Physician Reactions

Because our situation is unique, it is difficult to obtain meaningful physician reactions. Basically we doctors have seen no change in our pattern of delivering services. We do not know which patients belong to the Plan. Patients have free choice of physician. The major reaction came at the end of the first year when it was determined that, had we charged Plan members fee-for-service, we would have received slightly more income. As might be expected, the reaction was unfavorable. However, it did not materially alter our take-home pay because we all received full annual salary plus a little more. Again, several problems were obviated by the fact that we have a group practice and an equal salary program which is not affected by a physician

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taking care of patients in the Plan. It is my belief that the HMO concept, as it generally exists here and elsewhere, has not provided substantial incentive for physician involvement. The best argument for physician involvement is the continuing one, "If you don't do something about this, the Government will do something for you." Whether this philosophy is adequate or acceptable is certainly open to debate.

Patient Reactions

With very few exceptions, patient reaction to date has been highly favorable. It is significant that, to our knowledge, few left the Plan in response to our increasing the premium. Generally speaking, we believe that the Plan has produced some of our finest public relations.

New Rate Structure

When we reviewed our rate based on the first year's experience, we established a new structure starting July 1, 1972. Our comptroller computed a monthly cost of about \$7.70 per person for the care rendered by the physicians and Clinic during the first 16 months. Based on this experience, increased costs, and other projections, our initial calculation would have established a monthly rate near \$64 per family. Because this was believed too high by the Community Committee and the marketing group, we agreed on \$56.90 monthly per family and \$25.95 monthly per individual, broken down as follows:

Clinic Capitation -----	\$ 7.50
Hospital -----	\$ 5.84*
Referral Out-of-Area -----	.41
Blue Cross -----	.90
Total -----	\$14.65

* Equivalent to \$90 per day plus emergency room charges

A word of explanation about each of these. The capitation will be paid monthly as listed. However, in addition the Clinic has \$0.46 deferred capitation per participant per month billed into the premium. This will be paid in December and July if money is available in the fund. The Hospital figures include both inpatient and outpatient care. The inpatient services are based on the first year's utilization rate of 0.732 days per patient year. If money is available in December and July, they will receive up to \$0.03 per patient more per day for outpatient care. The cost of referral and out-of-area emergency services which originally accounted for \$0.95 of the premium has been reduced to \$0.41 based on the first year's experience with \$0.03 more allotted if needed and available. The administrative charge for Blue Cross has been reduced to \$0.90 and, if available, Blue Cross will receive an extra \$0.10 per participant.

If capitation deferred is added to the \$14.65 paid, the total monthly capitation is slightly higher than that listed above, and it is this multiplied by 3.7 that established the family rate of \$56.90.

We also agreed that we would no longer sell two single policies to a husband and wife. They now purchase the family program.

A very significant change in the basic concept has occurred, however. That is, we have agreed to a capitation arrangement by which we can receive up to the foregoing figures as a maximum but can recover no loss. Therefore, Hospital and Clinic now operate at a greater risk. If money is left over, it will probably be used initially to recover the losses incurred during the first 16 months of operation. Eventually, any surplus would be utilized to add more service or to stabilize the rate.

Philosophy

Government and health planners have been proposing the prepaid approach with the HMO philosophy so that the incentive will be to cut costs by providing fewer services and utilizing preventive medicine. Physicians would profit by avoiding overutilization, whereas, under the traditional fee-for-service arrangement, the incentive has been to provide more services for patients. This produces a real quandary about continuing maintenance of high quality medical care. However, it is possible that we may be able to save the patient costly duplication of diagnostic and treatment services by closer supervision.

As a referral center, we cannot afford to miss any diagnosis by ignoring the laboratory, radiology, and full consultation advantages that exist within our group. We do not identify our patients as members or non-members of the Plan. But we can identify the patient as living within our geographical service area. We believe we can avoid some costly diagnostic tests on an initial visit for people from our area since they will return if they need more medical care. Our group of physicians is so indoctrinated with the type of medicine practiced here for years that we have no major concerns about the quality of care suffering as long as we remain in control.

Having determined that we will sincerely try to accept the philosophy of prepayment and capitation, we are making a number of adjustments so that we can live and (we hope) grow with little change in our present capitation figure.

1. We will try to reduce the cost of medical care to people within our primary care area, primarily by educating our physicians to think in these terms and by reviewing hospital utilization and duration of hospital stay. We believe that the Home Nursing Service which

was not utilized during the first 16 months may provide help with this problem.

2. We will try, for what it may be worth, to educate our patients about how to use health-care services more effectively and get involved in preventive medicine, particularly immunizations, "Pap" smears, family planning, and the like. We hope to accomplish some of this by a monthly newsletter to subscribers written primarily by our physicians.

General Conclusions

We believe that the citizens of the United States today have "a right to access to good health care" as outlined. We believe it necessary for the medical profession to deliver as comprehensive total-quality care to all people as is possible. There must be a system that will provide accessibility of health care for all and which will ensure that the already sick and poor get adequate care. For that reason, we embarked on our prepaid capitation program as an experiment to see if it offered satisfactory alternatives. The answer is still unknown.

If we can expand our coverage to Title 18, Title 19, and the "near poor," this approach seems to have the advantage of maintaining dignity of all those enrolled by providing accessibility and equal care.

We believe that both fee-for-service and prepaid programs can be operated in a single medical setting and can be mutually beneficial to all patients. This is facilitated by group practice.

We believe it is vital to develop a peer review mechanism that will emphasize quality as an incentive as well as reducing costs.

It is difficult to reconcile the philosophy of preventive medicine as an advantage of the HMO concept; that is, our physicians and employees receiving benefit of preventive medicine for many years are the most expensive to take care of.

We believe that physicians and hospitals must get actively involved in the evolutionary process that is taking place in medicine. If they stand by as spectators or technicians, the political, governmental, and consumer forces will undoubtedly make radical changes in the delivery and financing of medical services which might not be in the best interest of our patients.

We jumped rather precipitously into our program after years of discussion but not much experience in planning. We feel we have learned a lot and, in retrospect, are happy that we proceeded early. Although we might have avoided some problems, at least we feel we are much farther ahead now than we would be, had we continued to plan in depth.

We are grateful to the Wisconsin Regional Medical Program for its help in funding a subsection

within our Foundation which is studying these areas in detail and from whom will come a number of reports in the next year.

It is my belief that prepaid capitation for an area like ours can be a voluntary mechanism for providing maximum medical services to all by spreading the risk to all. This, of course, is in contrast to the history of insurance programs which have stressed taking in well people and letting the poor and ill fend for themselves. If this mechanism proves successful, I believe it may be a desirable alternative to federal control which, by and large, is less sensitive to local needs and is considerably more expensive.

It is almost impossible to acknowledge all of the other individuals who worked to get this program going and keep it in effect. We want to especially thank Mr. David Jaye and the Sisters of the Sorrowful Mother representing St. Joseph's Hospital, Mr. David Neugent and his associates from Wisconsin Blue Cross-Blue Shield for their partnership and contributions. Special mention should go to Dr. Ben Lawton, President of the Marshfield Clinic when this Plan was instituted, for his leadership, and to Dr. David Ottensmeyer, the current President, for his leadership in the modifications. Mr. Floyd Deter and Mr. Brad Larsen, former Administrator and Assistant Administrator respectively, contributed greatly in the initial phases of the planning and the establishment of our Plan. Dr. John Mitchell and Mr. Bill Murray have been responsible for many of the statistics and will be reporting more in the future. Dr. Frank Lohrenz and Dr. G. Stanley Custer also helped in this respect. Mr. James Ensign, the Clinic's new Executive Director, has taken over many aspects of the Plan. Mr. Donald Nystrom has been in charge locally at the Clinic in the administration portion. Mr. Frederick Wenzel from the Marshfield Clinic Foundation has contributed, particularly to the Family Health Center grant. Special thanks go to all of these people who helped in writing this paper, especially Dr. Gerald Porter and Mr. Albert Zimmermann. □

THE GREATER MARSHFIELD COMMUNITY HEALTH PLAN

With the rising cost of health care and shortage of physicians and paramedical personnel, attention has been increasingly directed to alternative means of financing and organizing health services. Considerable attention is currently being focused on prepaid group practice plans.

The federal government is urging the health industry to participate in changes and innovations which show promise for improving the availability of care and controlling costs. The congress and the administration are encouraging prepaid group practice. Business and labor leaders are also interested in the exploration of health care innovations.

St. Joseph's Hospital, the Marshfield Clinic, the Wisconsin Blue Cross Plan, and Surgical Care Blue Shield spent considerable time in planning and reviewing existing information and programs. A prepaid group practice program has been made available to Marshfield and the immediate area. The Hospital and Clinic, by making their services more readily available through prepayment, expect to better serve the Marshfield community. There is agreement that it is time for greater unity of purposes and programs among community oriented institutions. The concept of prepaid group practice appears to be a constructive program that offers residents an opportunity to obtain comprehensive health care.

Sponsorship of a prepaid group practice in the Marshfield area is guided by these objectives:

1. To provide a broad range of services with emphasis placed on the prevention of illness, early disease detection, health maintenance, and alternatives to inpatient services.
2. To provide, through the prepayment mechanism, the opportunity to reduce costly paperwork.
3. To minimize rising health care costs.
4. To encourage the use of extended care facilities and a home care program whenever inpatient hospitalization no longer is necessary.

A community advisory committee has been formed, based on recommendations of the Clinic, the Hospital and others. This committee, with representation from employers, unions, farm groups, community groups, and consumers, assists in gathering support for the project, providing feedback and suggesting further approaches keyed to the needs of the community.

The program, which began March 1, 1978, is a community-wide effort to solve its health needs with an organized approach that makes maximum use of existing manpower and facilities.

SPECIAL ARTICLE

IMPACT OF MEMBERSHIP IN AN ENROLLED, PREPAID POPULATION ON UTILIZATION OF HEALTH SERVICES IN A GROUP PRACTICE

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Abstract Members of prepaid group-practice medical-care plans are believed to use more ambulatory, but fewer inpatient, services than populations served by fee-for-service practitioners. It is not known whether these differences are attributable to the prepayment aspects of the plan or to other circumstances. We studied the impact on use of services of only one factor—prepayment at the Marshfield Clinic, Wisconsin—with all other factors, including group practice, held constant. The findings

were derived from the experience one year before, and two years after, the initiation of the prepaid program. Results showed that prepayment alone resulted in significant increases in both inpatient and ambulatory care (about 100 per cent in ambulatory-care visits, 75 per cent in hospital discharges, and 60 per cent in hospital days). These increases were far greater than comparable increases in the fee-for-service population served by the Clinic. (*N Engl J Med* 292:780-783, 1975)

THE medical-care literature is replete with empirical studies reporting that persons enrolled in prepaid group practices use a greater volume of ambulatory-care services and, perhaps as a consequence, a lesser volume of inpatient services than comparable populations receiving their medical care through traditional fee-for-service solo-practice arrangements.^{1,7} This pattern of differential use has by now become the "conventional wisdom" in the medical-care field, and this wisdom, in turn, has apparently become the basis for public policy formulation regarding health-maintenance organizations (HMO's).

However, the medical-care literature generally fails to distinguish between prepayment and group practice as causal factors producing these differentials, and we have been unable to find any literature in which the problem is specifically addressed. This may be a serious omission because implementation of the "HMO strategy" as public

policy may realistically require, at least initially and in some parts of the country, that HMO's be superimposed on existing fee-for-service group practices rather than that they be established de novo. If group practice rather than prepayment is primarily responsible for the observed differentials, superimposition of prepayment on existing fee-for-service group practices may not produce the intended consequence of an increase in ambulatory care and a decrease in inpatient care.

The present study was able to address this problem directly by taking advantage of a "natural" laboratory setting. In the spring of 1971 the Marshfield Clinic, a fee-for-service group practice in Wisconsin, began operation of a prepayment arrangement covering only a portion of the population usually served by it. The remainder continued receiving services under their customary arrangements, so that for the two-year period covered by this study both populations existed side by side, each receiving services by the same physicians and in the same setting. The Marshfield Clinic had been routinely collecting data on use of its services before initiation of the new arrangements, and it continued to collect data subsequently. Because of the important public policy ramifications of these data, the Clinic

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when approached kindly offered the use of them for health-care research purposes, and acknowledgment is hereby gratefully made to the Clinic.⁸

BACKGROUND—THE MARSHFIELD CLINIC

The Marshfield Clinic is a fee-for-service multi-specialty medical group practice of long standing (in operation since 1916) with about 130 physicians, all remunerated by salary, on its staff. Its location is in the city of Marshfield in Central Wisconsin. In addition to its role as a referral center for Central and Northern Wisconsin, it serves a large primary population—about 48,000—consisting of residents of Marshfield and a rural and semi-rural population that covers approximately a 20-mile (32-km) radius (the Greater Marshfield Area). Within this area, the clinic physicians constitute the sole source of medical care except for six private physicians who practice in small towns at the periphery of the service area.⁷ All persons residing within the area are served by St. Joseph's Hospital, a 416-bed community general hospital located within the city of Marshfield, and most were covered by Blue Cross and Blue Shield or commercial insurance carriers (or both) under standard arrangements (i.e., excluding home and office visits). In March, 1971, the Marshfield Clinic began operation of a prepayment program (the Greater Marshfield Community Health Plan) as a joint venture with St. Joseph's Hospital and the Wisconsin Blue Cross and Surgical Blue Shield of Milwaukee. The prepayment arrangement was offered as an option to various industrial and other employers. Groups were formed for purposes of enrollment, with many accepting the prepayment option. When the option was available to group members, about 98 per cent participated in the arrangement. Two open enrollment periods are held each year for individuals other than groups. As of 1973, about 76 per cent of the members of the prepayment arrangement had been enrolled through a group, whereas about 24 per cent were individual enrollees. It is believed that generally the Clinic physicians do not know the payment status of the vast majority of patients presenting.^{8,9}

METHODS

The routinely collected information derived from various encounter forms and stored in the files of the Marshfield Clinic served as the primary source for data on ambulatory-clinic visits, hospital outpatient-department visits (emergency room), and discharges from St. Joseph's Hospital. Data on the number and characteristics (age, sex, place of residence, and payment status) of Plan members were obtained from a current patient master file. Estimates of the number of characteristics of persons

classified as paying "fee-for-service" were derived by subtraction of the numbers of Plan members and Medicare and Medicaid recipients from data derived from the 1970 Census,¹ with projections to subsequent years.¹⁰⁻¹² All rates shown in the tables presented here were adjusted for age and sex to the 1970 population of the Greater Marshfield Area.

Finally, the Greater Marshfield Area was separated into two zones, with Zone 1 defined as the city of Marshfield and a 5-mile (8-km) radius outside it. Zone 2 was an outer band covering an area 5 to 20 miles (8 to 32 km) from Marshfield. Approximately 50 per cent of the population of the Greater Marshfield Area, and coincidentally 50 per cent also of the prepayment population, resides within Zone 1 and the remainder in Zone 2.

STUDY RESULTS

The use of ambulatory-care services doubled for the prepaid population from the first year of the study before the initiation of prepayment to the second when prepayment existed (Table 1). The rate of visits per person per

Table 1. Total Ambulatory-Care Visits by Prepaid and Fee-for-Service Populations before and after Prepayment.*

PERIOD	VISITS/PERSON IN POPULATION/YR	
	PREPAID	SEE-FOR-SERVICE
1st study yr (yr before prepayment)	1.84 [†] (17,292)	1.34 (24,317)
2d study yr	3.69 [†] (7,617)	1.49 (24,326)
3d study yr	3.68 [†] (14,200)	1.73 (24,360)

*The double line in the table represents the initiation of operation of the prepayment arrangement. Thus, the prepaid population was actually operating on a fee-for-service arrangement during the yr before prepayment. All rates adjusted for age & sex to the 1970 population of the Greater Marshfield Area. Figures in parentheses represent the average crude population-at-risk by yr computed on a person-mo basis. The prepaid population, in the "yr before prepayment," includes all persons who subsequently enrolled in the prepayment arrangement. The figures in parentheses in the 2d & 3d study yr include only persons actively enrolled. Persons awaiting enrollment or no longer enrolled are not shown, nor is their utilization reflected in this table. P values were derived by analysis of variance & the F statistic.

[†]Difference between prepaid & fee-for-service significant at $p < 0.005$.

[‡]Difference between prepaid & fee-for-service significant at $p < 0.001$.

year rose for this population from 1.84 to 3.69 from the first to the second year, a 100 per cent increase. In contrast, the comparable change for the fee-for-service population was from 1.34 to 1.49 visits, an increase of only 11.2 per cent (not statistically significant) during the same period. This effect persisted during the second year after the establishment of the prepaid arrangement, with the prepaid group remaining at a high level, 3.68 visits per person per year, whereas the fee-for-service utilization rate rose slightly. This time it rose from 1.49 to 1.73, an increase of only 16.1 per cent that, once again, was not statistically significant.

*We are indebted to the physicians of the Marshfield Clinic, the administration of St. Joseph's Hospital, the staff of the Greater Marshfield Community Health Plan, and the Blue Cross and Surgical Blue Shield of Milwaukee. Special recognition goes to Mr. Gregg Nycz, data analyst of the Marshfield Clinic Foundation, for assistance in providing statistical advice and consultation.

[†]These physicians do have an arrangement with the Marshfield Clinic through which they provide services to a small number of members and are reimbursed on a fee-for-service basis. However, their experience with Plan members is not included in this study.

¹The total census population for the Greater Marshfield Area for 1970 (composed of 46 towns and townships-minor civil divisions) was 47,925. Subgroups according to Payment Status consisted of the following: Census, 47,925, minus Plan Enrollment (ever enrolled in the prepayment plan), 17,292, minus Medicare (beneficiaries with Part A and B entitlement), 5105, minus Medicaid, 1211, equals fee-for-service, 24,317. The clinic updates the files monthly to detect population changes or errors (or both). To date the error rate has been less than 0.5 per cent. The errors have been missing information (e.g., age or sex) and are corrected when the patients return for care.

Table 2 shows these data according to site of ambulatory-care visit. It is clear from these data that the increase in such visits among the prepaid population after the initiation of prepayment occurred in both clinic and hospital outpatient (emergency-room) settings. Thus, in the clinic setting, visits per person per year rose from 1.73 before prepayment to 3.35 and 3.23, respectively, during the second and third study years. In the fee-for-service population the comparable rise was from 1.24 to 1.34 and 1.50. In hospital outpatient visits (emergency room), the impact of prepayment was again substantial, with visits per person per year rising from 0.11 to 0.34 to 0.45. The fee-for-service population also experienced a substantial increase, from 0.10 to 0.15 and 0.23, but not as much as was experienced by the prepaid population.

Not only did ambulatory-care services increase with the establishment of prepayment in this population, as was expected, but use of in-hospital services also increased—in this instance quite contrary to expectation. The dimensions of this increase are shown in Table 3. Thus, average annual days of hospital care per 1000 population rose for the prepaid population from 413.5 before prepayment to 656.5 in the next year, an increase of 58.8 per cent, whereas for the fee-for-service population, the comparable rise was from 408.4 to 464.3, an increase of only 13.7 per cent. For both populations, however, there was a slight decrease from the second to the third study year: from 656.5 to 635.4 for prepaid population, a decrease of 3.2 per cent, and from 464.3 to 414.6 for the fee-for-service population, a decrease of 10.7 per cent. The prepaid population hospital discharge rate increased after prepayment from 61.4 to 107.8, an increase of 75.6 per cent. The fee-for-service population discharge rate increased by only 11.6 per cent. Average length of stay decreased as a consequence of the prepayment, from 6.73 to 6.09 days, in the second study year. It increased, although slightly, during the third study year, to 6.26 days.

DISCUSSION

A portion of the results of this study run counter to the conventional wisdom so far as the impact of prepayment on use of medical-care services is concerned. That is, whereas ambulatory-care services rose substantially, inpa-

Table 3. Utilization of In-hospital Services by Prepaid and Fee-for-Service Populations before and after Prepayment.*

PERIOD	POPULATION & MEASURE OF UTILIZATION					
	PREPAID			FEE-FOR-SERVICE		
	days/1000 population	discharges/1000 population	average length of stay (days)	days/1000 population	discharges/1000 population	average length of stay (days)
1st study yr (yr before prepayment)	413.5	61.4	6.73	408.4	60.4	6.77
2d study yr	656.5 [†]	107.8 [‡]	6.09	464.3	67.4	6.89
3d study yr	635.4 [†]	101.5 [‡]	6.26	414.6	66.2	6.26

*The prepaid population, in the "yr before prepayment," includes all persons who subsequently enrolled in the prepayment arrangement. p values were derived by analysis of variance & the F statistic.

[†]Difference between prepaid & fee-for-service significant at $p < 0.005$.

[‡]Difference between prepaid & fee-for-service significant at $p < 0.001$.

tient services also rose, contrary to what we had expected. This finding must be considered in the light of a number of possible limitations and qualifications resulting from the study situation and method.

To begin with, this was a "natural" experiment. In the very nature of the case, the experimental and control groups were not randomly selected, but rather were those who occupied these positions naturally. The experimental group was to some degree self-selected—i.e., they were the people who, when offered the option, voluntarily enrolled in the prepaid arrangement. They may have been "sicker," or they may have anticipated a greater need for care than was anticipated by the others. In this sense, those who remained in a fee-for-service arrangement were also self-selected. The selection factor may have operated more strongly on those who enrolled in the prepayment arrangement individually (24 per cent of those who enrolled during the study period), but even among those who enrolled as part of a group (76 per cent of enrollees), it must be assumed to have operated, at least in some degree. There simply was no way to eliminate this possible qualification to the findings.

Some support is given to the self-selection factor as biasing the results when comparisons are made between the ambulatory-care utilization rates of the prepaid and fee-for-service populations before the inception of the prepaid arrangement (Tables 1 and 2). These comparisons show that the population that elected prepayment did have a substantially higher utilization of ambulatory services than the population that remained on a fee-for-service basis, but this difference was definitely not apparent for utilization of in-hospital services (Table 3).

Secondly, what was observed here may have been merely the short-term or temporary effects of the new arrangement, rather than anything long-term or permanent. The rationale here may be as follows: populations suddenly on a prepaid arrangement, with zero out-of-pocket costs (as compared to previous fee-for-service direct costs), would be expected to increase their use of

Table 2. Ambulatory-Care Visits According to Site by Prepaid and Fee-for-Service Populations before and after Prepayment.*

PERIOD	VISITS/PERSON IN POPULATION/YR & SITE			
	PREPAID		FEE-FOR-SERVICE	
	clinic	hospital outpatient	clinic	hospital outpatient
1st study yr (yr before prepayment)	1.73 [†]	0.11 [‡]	1.24	0.10
2d study yr	3.35 [†]	0.34 [†]	1.34	0.15
3d study yr	3.23 [†]	0.45 [†]	1.50	0.23

*See 1st footnote in Table 1.

[†]Difference between prepaid & fee-for-service significant at $p < 0.005$.

[‡]Difference between prepaid & fee-for-service significant at $p < 0.025$.

[§]Difference between prepaid & fee-for-service significant at $p < 0.001$.

ambulatory care. But the consequence of this increase in use may be that many more conditions requiring in-hospital services are picked up by the physicians, so that in-hospital use increases. But, once this backlog of needed in-hospital services is eliminated, in-hospital utilization may be sharply reduced in subsequent years. Thus, the long-term consequences may be a reduction in in-hospital services as increased ambulatory care provides the preventive services that prepaid programs are expected to provide. Perhaps these results would have been shown if the present study had continued for several additional years. But, at least to the present, the study findings do not indicate such a reduction.

Thirdly, it must be emphasized that this study was conducted in only one setting, a rural area in which a fee-for-service group practice of long standing was operating. There may have been special features in this setting, unknown to us, that make it atypical and therefore preclude generalization of the findings to other settings or to the nation as a whole. Some evidence for this reasoning is provided by the low utilization rates, both ambulatory and in-hospital, characteristic of this population before prepayment, even when compared to rural areas in the United States. In turn, it may be speculated that these low rates were due to the use of other providers and other facilities, especially by populations residing at the periphery of the service area. (The statistical data, not shown in the text, seem to confirm this hypothesis.) If this speculation is true, the higher rates of utilization for the study population after initiation of the prepayment arrangement may well be due to their limiting their sources of care to the Marshfield Clinic because their insurance coverage no longer left the choice of providers to them.

Another point that might be made here is that Marshfield Clinic physicians, both before and after initiation of the prepayment arrangement, were remunerated by salary. Thus the low utilization of the Marshfield population (as compared to the general, rural United States population) might in part be explained by the lack of incentives for Marshfield physicians to encourage high ambulatory use, unlike the situation in traditional fee-for-service practice prevailing in the rest of the United States, even in rural areas.

Fourthly, it is believed that most physicians in the Marshfield Clinic did not know the payment status of their patients—i.e., they did not know whether the patients were in the prepaid or fee-for-service groups. In this respect the situation described here was unlike that existing in the usual prepaid group practice, where in the very nature of the case physicians do know the payment status of their patients—i.e., they do know that patients are covered for the full range of services outside the hospital and will not suffer any financial penalty if managed outside it. This circumstance may explain in part the lower hospital

utilization experience of prepaid group practices as compared to traditional fee-for-service (the so-called conventional wisdom), and it is one more circumstance precluding generalization of the findings of the present study to the usual prepaid group-practice situation.

Finally, it is difficult to interpret the meaning of the increased in-hospital utilization by the prepaid population because of the lack of data on diagnosis, or even on whether the admissions were for medical, surgical, or obstetric conditions. If such data had been available, they might have told us whether the increases in admissions were "necessary" or "discretionary."^{13,14}

In addition to limitations discussed earlier, one deserves special mention. Since the prepaid population, during the period of the study, constituted a relatively small segment of the population served by Marshfield physicians (one third of the patients in the service area and about 15 per cent of all patients seen by these physicians), it seems probable that the behavioral patterns and other aspects of the *modus operandi* of the Clinic physicians remained relatively unaffected by the new prepayment arrangement. In this sense, also, the Marshfield situation was unlike that of the usual prepaid group practice, and additional studies elsewhere are necessary before the implications of our findings for public policy can be assessed.

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Lessons from an HMO launching

After a year
New men size up groups



Lessons from an HMO

By David J. Ottensmeyer, MD

Looking back over the last five years, we've learned quite a bit about what starting an HMO really means to a fee-for-service, multispecialty group. Today we have an HMO that's serving more than 17,000 participants (representing about 12% of our practice), and evidently it's a going concern. But along the way we made several mistakes, had considerable bad luck, and experienced surprises both pleasant and unpleasant. I'd like to discuss our well-learned lessons point by point in the hope that other groups starting HMOs will achieve their goals less painfully than we did, and perhaps with fewer surprises and less reliance on luck.

Impress upon your group from the start that an HMO is a major change and not merely a new wrinkle in your accounting procedures. It is foreign to the fee-for-service concept, it submits a group to unaccustomed risks, and its future is a big question. Selling an HMO as anything less than that could cause an uprising on your medical staff within a matter of months.

Our HMO lost money the first year. If our executive committee Dr. Ottensmeyer is president of the Marshfield (Wis.) Clinic

had not explained the HMO concept fully to the medical staff and had it not kept the staff informed of the HMO's monthly status, the HMO could have blown up in our faces.

Make sure the medical staff understands completely what your HMO plan provides. Our apparent failure to do so is one of the reasons we lost money. One of our physicians told a public gathering that, by his figuring, a childless couple consisted of two individuals, so they could purchase two individual contracts—at that time for \$17 apiece. Our calculations, however, were based on a couple paying the family rate, or \$49.80. But for a year we had to sell them individual contracts, leading to an actuarial underestimate of average family size which helped to put our HMO in the red.

Get expert on-site help. A group with an HMO must have someone available who understands the esoterica of insurance contracts and rate setting; it is indeed a foreign language. Unless there's someone who can explain terms such as "contingent liability" in language your physicians can understand, you're going to have trouble winning their trust.

We were fortunate that about a year after our HMO started, we

hired a former vice president of Blue Cross Association of America to be our executive director. His responsibilities are clinic-wide, but he stepped into our HMO effort without losing stride, and we rapidly learned how deep our ignorance was. He has since proven invaluable in keeping us informed and giving us a much-needed feeling of security. I would suggest that unless a group is geographically tied in much more closely with a prepayment carrier than we are (Blue Cross is based in Milwaukee), that group consider hiring someone from the health prepayment field. Otherwise it could be just a babe in the HMO woods.

Add staffing specifically for primary care. We thought we wouldn't have to. In fact, until recently our group didn't even think about primary care, nor did we hire primary care physicians. Even those of our staff in internal medicine, pediatrics, and Ob-Gyn considered themselves to be strictly specialists; in recent years particularly, most young internists have mainly wanted to subspecialize. But when we started our HMO, agreeing thereby to provide subscribers with total health care, we found we couldn't ignore primary care any longer. It's proven to be a difficult adjustment. Recently

launching

we did create a primary care department consisting of two general internists, a family practitioner, and an internist who is board-certified in preventive medicine, and an emergency room physician, so we're finally staffed to provide primary care. Yet we're finding this an area of continuing consternation.

Be prepared to provide for increased administrative responsibility. This is something else we felt wouldn't be necessary; we thought we could impose an HMO on our administrative staff without much trouble. It hasn't worked out that way. We've created a position for a full-time insurance manager to handle day-to-day problems. Further, our electronic data processing department has assumed a considerable burden in writing computer programs, collecting data, and writing reports. And the personnel in our comptroller's office spend a great deal of time at certain periods of the year evaluating data and setting rates.

If you work with an insurance carrier's representative, make sure your group has the horsepower to deal with him if he tries to tell you how to practice medicine. I think I lost nearly five years of my life a few years back when a high-pow-

ered insurance executive confronted us with a stack of medical records and proposed to show us how to cut costs. His idea was to change the way we were handling cases from a medical standpoint. Things came to a screeching halt right there, and that hasn't been an issue since. That's the sort of situation a group must be prepared for when it goes to bed with an insurance carrier.

Keep a close watch on your HMO's utilization patterns; there could be some surprises. Oral surgery, for example, can be dynamite in a prepaid program—at least that's been our experience. We discovered fairly soon that there's an awfully big reserve of impacted wisdom teeth out there; indeed, during one month 18% of our prepaid ambulatory utilization was for removing them. By the same token, we've discovered an area of apparent need, so we have considered adding some of the other dental specialties to our clinic in the near future.

Don't be afraid of community involvement in running your HMO. Because we felt we should have some guidance from the community in organizing our program, we sought out respected representatives from business, labor, education, agriculture, government, and

the clergy, as well as several housewives, to form a community advisory committee. Admittedly, it can be hard on physicians' arteries when, having come up with a carefully calculated package of cost projections and premium rates, they hear a group of businessmen and housewives tell them that it's just too expensive. It can seem like idiocy flying in the face of reason. But we've found that our community committee is well worth listening to and, among other things, it's proven to be of considerable benefit in keeping our rates realistic and our program in touch with the community.

Make sure you have an optional arrangement for your prepaid patients should the HMO not work out. Remember, you've assumed responsibility for the total health care of perhaps thousands of patients. If our plan were to discontinue, its participants would have conversion privileges to regular Blue Cross/Blue Shield coverage. However, our HMO has become so popular in our community that it's probable we'd need more than financial reasons to get out of it. In fact, getting out of it for any reason could prove to be very rocky and unpleasant. That's why we've decided that our HMO just has to work—period. □

The Marshfield Clinic...



For the one in four

The Marshfield Clinic...

It is an uncommon Clinic, and because it is so, only one doctor in four will want to practice here.

Who is that one? What is he searching for?

There are 117 physicians — all specialists — at the Marshfield Clinic. And today we are seeking more doctors. We think we know the kind of person who will most enjoy practicing with us. We believe we know the facilities and colleagues who will most appeal to him.

That's what this booklet is all about. Simply to interest one in four doctors in joining us. And, to be candid enough in our description and explanation so as not to overly encourage the other three. We have tried to tell it as it is; no exaggeration or puffing up of what we are not. But, also, no false humility in describing what this clinic is all about.

Take 30 minutes, if you will. Read the profile we drew of the man who would thrive in this medical setting.

Then, simply ask yourself if you might be the one in four.

If the answer is yes, tell us of your interest. We will arrange, at your convenience, for you to visit us at the Marshfield Clinic.

The Executive Committee,
The Marshfield Clinic

Marshfield, Wisconsin 54449 Area Code 715/387-1711

The One in Four — What is his Philosophy of Medicine?

At the Marshfield Clinic we feel we have the best of clinical medicine and many of the advantages of academic medicine as well. The doctor practicing at the Marshfield Clinic is both a student and a teacher. He may even have considered academic medicine as his profession. But, then, he may have discovered that some of those practicing and teaching at outstanding clinics know their fields as well as the best medical school professor.

So, the physician has made his choice of practicing clinical medicine. Tough referral cases challenge him. From them this physician learns more of his specialty. But, he does not want a burdensome patient load to preclude study, teaching, or possibly research, and his publishing in the journals.

The doctor practicing at Marshfield is prideful that 15 of his colleagues are teaching at the University of Wisconsin or the University of Minnesota Medical Schools. He may want his paper to be among the nearly 100 expected to be published by Marshfield Clinic doctors next year.

Clinic policy encourages members of the staff to be gone up to six months studying in their fields at some medical school or research center. The fact that their salaries continue while they are away is further evidence of the vital part academic medicine plays in the Clinic's routine.

Every Clinic doctor is encouraged to participate in the several teaching conferences at the hospital. Conferences at St. Joseph's Hospital cover such subjects as cancer, X-ray, neurology, pediatrics, and internal medicine. Nationally known guest speakers highlight regular scientific meetings held in the Clinic library.

In short, there is more emphasis here on scientific medicine than on medical economics. The man who practices at the Clinic wants it this way.

The Marshfield Clinic doctor believes that the specialist in group practice is imparting the finest patient care possible.

He seeks medical security, because he is wise enough to know what he does not know. Our Dr. Fullerton, a psychiatrist, has written that during residency, physicians discover they must share the responsibility for patient care with specialists in other fields. Here the new member quickly learns to function as a member of a team rather than as a solitary omnipotent leader.

Those doctors who like it here have the attendant qualities of thoughtfulness, courtesy, and the ability to communicate.

"The finest patient care possible" begins with the assurance that

just down the hall is another competent specialist whose scholarship and ability you respect.

The Marshfield Clinic physician may complain at Board meetings that we are overstaffed in ancillary services; but he is never



A Saturday morning X-ray conference at the hospital is typical of these weekly sessions for clinic doctors. Conferences, seminars, leaves of absence for study dramatize the atmosphere of academic medicine practiced here.

short of needed help. X-ray technicians, medical technologists, nurses — they are always on duty. Because we may need radiologists, pathologists or anesthesiologists at 4:00 A.M., they are always available.

Equipment — if it's new and he needs it for patient care — the doctor is expected to request that the Clinic buy it. And, it usually will be bought. If it's commonly used in the medical schools and university hospitals, we probably already have it in Marshfield.

Every doctor here feels a constant, subtle pressure for excellence. He is stimulated by this to advance his medical knowledge.

The idealism appeals to the idealistic doctor. He is not judged by his quantity of work, but by his quality. A doctor who will push himself intellectually will be happiest here.

For most of the physicians joining the Clinic, the emphasis on excellence has been challenging. For a small number it has been too demanding; the obligation to every other doctor in the group has been a drawback. These few have left the Clinic, as well they should. But, we are proud that we have lost so few men over the last 20 years.

As was said earlier, it is an uncommon place. The Marshfield Clinic is only for one in four doctors.

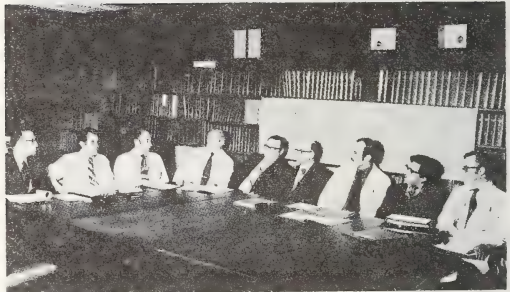
The One in Four — He is a director in the Clinic nobody owns.

Six physicians agreed in 1916 "to pool our resources and the Clinic will own . . ."

Those words are still the key to understanding the unique medical organization in Marshfield, Wisconsin.

The man joining the Clinic today as an associate physician in a specialty will be either board eligible or certified. This position — with subsequent annual salary raises — continues for two years when the man then becomes eligible for membership on the board of directors.

The executive committee is the working arm of the board of directors and is elected by that board. Every physician who remains at the Clinic for two years becomes a board member with equal voice in policy and operation. Meetings take place weekly.



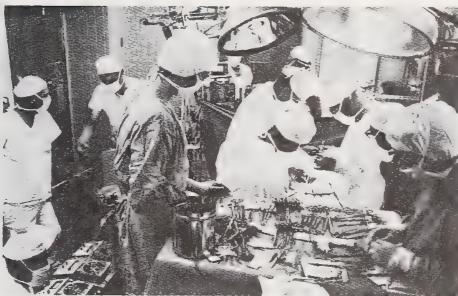
The doctor who wants to stay with the Clinic also wants to help manage the Clinic. He feels more comfortable working for an organization in which he shares in management. Once he pays the nominal \$1,000 for his membership certificate he has just as much to say about running the Clinic as any other doctor. Like every board member in the corporation he has one vote. One member puts it, "We have no caste system here. Everyone helps run the shop."

As a Board member he votes annually for all Clinic officers, including the members of the executive committee. The Board meets monthly to review the actions of its working arm, the nine man executive committee, and makes all major decisions.

The new physicians will find that the Clinic is basically a democratic organization with the usual problems of democratic action. But we believe that for over 50 years no one has found a better way to run a Clinic, and the new man agrees in principle with this. He wants his voice heard equally with all other voices. (And at times he has to shout to make it so!)

The associate physicians meet regularly with the Board, and their viewpoints are asked on policy matters.

In short, the physician who likes it here is a mature person. He functions well in an atmosphere of medical freedom, needs little or no supervision in his quest to provide the best possible patient care. He has his own ideas on Clinic management, and thrives where his voice is heard and his suggestions considered.



Open heart surgery performed at St. Joseph's Hospital since 1962 — the doctor practicing here demands the latest of sophisticated equipment, skilled technicians and ancillary services, and his demands are met.

The one doctor in four who would practice here wants the finest in equipment and the best of ancillary services.

One Clinic doctor has proudly noted that "all I own in this office is that clock and tobacco jar".

One of the principles responsible for the growth of this Clinic is that the patients coming here expect something extra in the way of medical care. Many of the daily 800 patients are referral cases from physicians and areas up to 150 miles distant. These patients, and others who come on their own, expect more here than would be available from their home physician.

They see the large medical clinic building in a small town called Marshfield. Large, comfortable waiting rooms are located on each floor. Patient handling is geared to honoring appointment hours, so that seldom does a patient wait long after arriving at our registration desk. Floor space is allotted to give each physician adequate office space and office clerical staff.

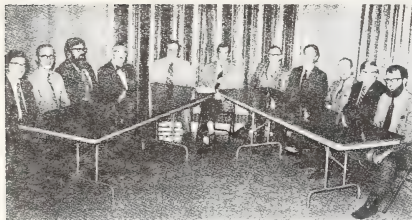
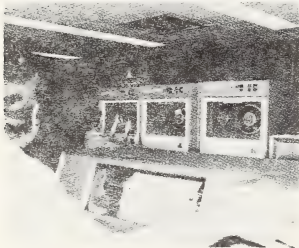
Our doctors demand the most sophisticated equipment and the best of technicians and nurses. The man practicing here is often more eager to expand ancillary services and buy new equipment than have the board increase physician salaries.

"This way we won't get rich," one of our men stated, "but we will always buy the equipment needed for the best medicine possible."

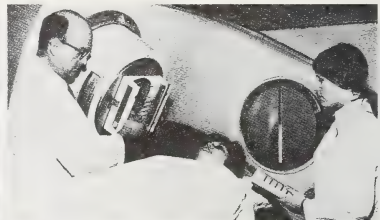
Some of that equipment includes:

—A fully equipped and automated clinical laboratory with an SMA 12/60 autoanalyzer. Most tests are reported while the doctor is with the patient. Metabolic studies including plasma and urinary steroids, protein bound iodines and plasma renins are possible.

Doctors here disdain paper work, and the data processing center plus 3.5 para-medical employees per physician relieves them of many such details. The data processing machines are being programmed more and more to assist the doctor in his medical practice.



A psychiatric department staff meeting finds clinical psychologists with PhD's, five social workers with MA's, and the psychiatrists discussing department problems.



The Linear Accelerator is one part of a complete program in radiation oncology.

- An analytical ultracentrifuge for research work.
- Specialized gastroenterologic capabilities including a colonoscope, gastroscopy, gastric photography, gastric cytology, esophageal motility testing and secretin tests.
- Cardiopulmonary laboratory with facilities for all forms of angiography including coronary arteriography; left and right heart catheterization; phonocardiography and pulmonary function studies including diffusion and blood gases.
- Pump oxygenator for cardiopulmonary bypass.
- A unit for hemodialysis.
- Modern X-ray facilities at the Clinic including image intensification and fluoroscopy with TV monitoring on all units; a Siemens multiplanigram and facilities for intra-oral dental X-rays.

The data processing center has been developed for both medical assistance and for clerical services.

Physicians here, as elsewhere, disdain paper work. In fact, they are too busy practicing medicine to be bothered. The Clinic makes a special effort to eliminate all but necessary procedural detail. This is one of the reasons for our ample ratio of 3.5 paramedical employees per physician.

Personnel — *excluding doctors* — number almost 600 people.

Treating the whole person is the goal of the man who would practice medicine at the Marshfield Clinic. He is, therefore, interested in five clinical psychologists, two neuro-psychologists, and five bio-chemists — all Ph.D's — being on the staff. Also, the five staff social workers associated with our department of psychiatry — all with their master's degrees — augment the treatment of the "whole patient".

The doctor searching for a sophisticated, scientifically stimulating environment will find it at the Marshfield Clinic.

The Clinic demands a fine, superbly equipped hospital, well staffed, precisely run.

Because we demand just that, the new doctor must also. For the 117 Clinic doctors are virtually St. Joseph's Hospital's medical staff. This is no average community hospital for a town of 15,000. Instead, it is a 416 bed establishment owned and operated by the Sisters of the Sorrowful Mother. Current plans call for further expansion and additional services in conjunction with the new construction plans of the Clinic.

Facilities for all fields of medicine are available. Included is a psychiatric wing, a department of physical medicine, a chronic disease unit, intensive care unit, coronary care unit, new operating and delivery rooms, and a linear accelerator unit. Open heart surgery has been done since 1962; hemodialysis for eight years; cryosurgery and just about all other specialized surgical procedures are also accomplished here.

St. Joseph's Hospital School of Nursing has over 100 student nurses in training.

The doctor joining the Clinic expects an instant practice among peers he can respect.

He has no desire to spend three or four years building a practice. But, because he is searching for the happy combination of patient care, research, and ample time for advanced education, he does not want the patient load oppressive.

"Semi-academic" and "scientific" are adjectives used to modify the "medicine" he would practice.

The man we seek is probably young, but not necessarily. This doctor is idealistic in his desire to practice the best medicine possible in the last third of the 20th Century. But, he is surprised to find that he shares that idealism with men almost twice his age.

Because the physician demands the best of himself, he demands equally of the clinic staff about him. One of our newer internists put it this way: "When I call on a urologist I want to be damn sure he knows his stuff."

As was mentioned earlier, before the physician comes to see us, he has determined that group practice is the best way for him to practice medicine. He sees the Clinic as a place to take care of the patient as a whole. Therefore, the doctor does not see single specialty groups as the best clinical medicine. Rather, he is set on associating with a multi-specialty Clinic abounding with sub-specialists.

This is a free-wheeling sort of place, perhaps typically mid-western in its lack of stuffiness and protocol. Hierarchy, seniority worship — he will not find them here. So, if he wants a formalized, strictly structured clinic, best he search elsewhere.

The young associate who said that spoke for many of our people. Here, then, are some Clinic and staff credentials that bespeak the quality we talk about:

—Fifteen physicians have academic appointments at the University of Wisconsin or the University of Minnesota Medical Schools.

"The opportunity to associate with the doctors here is the second greatest opportunity of my life . . . after my kids."

—Twenty one of our people made 1971-72 presentations at national or interstate meetings. 96 papers were presented at state, regional and national meetings; plus 65 papers were written in 1972.

—Twelve physicians recently took advantage of the Clinic's "back-to-school" program. They have studied at Minnesota, Wisconsin, Harvard, Mayo's, Sweden and London.

The Marshfield Clinic Foundation for Medical Research and Education appeals to the man practicing here.

He may need a Clinic with a research arm to exploit his own interest in academic medicine. The Foundation, quartered in its own building near St. Joseph's Hospital, continues to expand its research programs each year. Increasing physician interest as well as private and public sources has made this expansion possible.

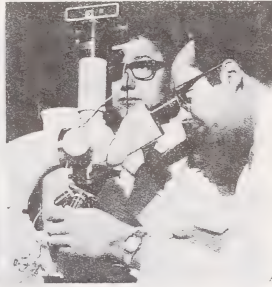
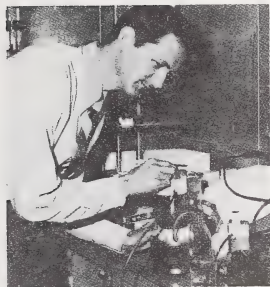
The laboratory staff of the Foundation has grown to over 30 full time people including four Ph.D investigators who are engaged in both basic and applied clinical research. About 20 Clinic physicians participate in an equal number of projects.

Just a few of the 50 current projects are:

- Pulmonary Specialized Center of Research
- Studies on the Role of Renin in Hypertension
- Physician Assistant Program
- Studies of Fertility and Sterility
- Coronary Drug Project, Effects of Drugs on the Natural History of Coronary Artery Disease
- Investigation of the Sensitization Potential of Cosmetics
- Use of Gallium in the detection of cancer
- Family Health Center assisting the economically disadvantaged
- North Central Outreach Project (Shared Services)



Ronald Roberts, PhD, one of the investigators at the Clinic Foundation research center uses the ultracentrifuge in his studies.



The foundation exists for other than applied and basic research. It sponsors educational programs and informational sessions for students, Wisconsin citizens, and physicians. The Foundation staff serves on the teaching staff at the University of Wisconsin, Marshfield-Wood County Campus. Also, the Foundation is basic to the continued training of our professional staff on a post-graduate level, the intern and residency programs. The Foundation is also involved in community service through the sponsorship of programs for those requiring minimal psychiatric care.

An educational program involving medical students and house staff is vital to the physician who will practice here.

He is confident in his knowledge and ability and may want to teach others. Also, he recognizes a residency program adds to the professional environment.

The Clinic has provided preceptee training for the University of Wisconsin Medical School since the inception of the program.

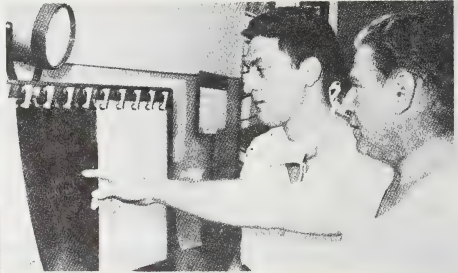
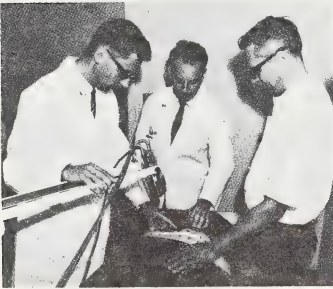
The residency program at Marshfield includes surgery and dermatology and several other fields in which electives can be taken. An affiliated internal medicine, residency program with the University of Wisconsin Medical School has been implemented. Several other specialty residency programs will be in operation in the immediate future.

New trends in medicine are explored here.

Despite the fact that the doctors' practices are large, the referral area wide and growing continuously, the Marshfield Clinic has been increasingly concerned with the major problems facing medicine today. The directors have involved themselves in seeking new methods for delivering health care services, enlarging the scope of present services to cover those not already adequately cared for, and trying to elevate the standards of medical care in the predominantly rural areas far removed from adequate medical facilities. The Clinic has been working closely with federal and state agencies including the Comprehensive Health Planning agencies.

LOWER LEFT:
Dermatology residents from the University of Wisconsin Medical School work with Dr. Schorr of the Clinic staff.

LOWER RIGHT:
A resident in surgery at the Clinic studies a chest X-ray with Clinic thoracic surgeon, Dr. Lawton.



Prepaid Comprehensive Health Plan receiving national attention.

Much attention has been given in recent years to alternative means of financing and organizing health services in rural areas of our nation.

In 1969, the Marshfield Clinic and St. Joseph's Hospital of Marshfield began to search for ways to cut costs without jeopardizing the quality of health care delivery. It was about the same time the federal government also became concerned that health care costs were getting out of hand.

Two years later, in 1971, with the cooperation of the Wisconsin Blue Cross and Surgical Care Blue Shield programs, the Greater Marshfield Community Health Plan was introduced.

A large, 117 physician specialty group practice coupled with an excellent 416 bed hospital facility serving the greater Marshfield community through the availability of a comprehensive, prepaid health plan was once a dream. Now it is a reality and is one of the few rural prepaid health plans of its kind in the country.

Since 1971, the Greater Marshfield Community Health Plan has been dedicated to serving the total health needs of those living in the area. More than 15,000 people, 40 percent of those people eligible living within 20 miles of Marshfield, are now participants in the prepaid health plan. It is anticipated that in the near future, there will be almost 25,000 participants in the plan.

Regional Services (Shared Services) are available to Wisconsin hospitals and solo practitioners for greater efficiency and improved health care delivery.

Services offered include:

EKG - Automated systems utilizing telecommunications via data phones, telecopiers and a computer.

REMOTE CARDIAC MONITORING - Remote continuous cardiac monitoring expected to be made available soon.

CLINICAL LABORATORY - Clinical laboratory specimens currently being received from 18 medical institutions through shared services.

CONSULTATION - Psychiatry, psychology, psychiatric social services and neurology consultation services are being utilized by several facilities in northcentral Wisconsin.

NUCLEAR MEDICINE - Scanning and laboratory operation consultation services are available to private practitioners and health institutions.

PEDIATRIC NEO-NATAL EMERGENCY CARE - Specially equipped rescue ambulance and a doctor are always available.

"Our goal: To improve the quality of life in the Marshfield area."

The Greater Marshfield Community Health Plan is designed to do just that. The people at The Marshfield Clinic and St. Joseph's Hospital two years ago stopped talking and began doing something about filling one of the most critical needs of our time: The need for a new way to finance delivery of health care services in the face of constantly rising costs.

Blue Cross and Surgical Care Blue Shield agreed to administer enrollment and billing services. Today, over 15,000 area residents are receiving their health care through the Plan.

These citizens pay two low monthly rates, one for single persons another for a family of any size. In return, they are guaranteed nearly complete health care - including 365 days in the hospital, surgery, X-ray, laboratory and all procedures, immunization and physical exams - from sore throats to major surgery and all out-patient costs as well.

This prepaid group practice is geared to doing all that is necessary to sustain health rather than merely treat illness. Our physicians and our patients are equally pleased with the results so far.

The physician whose foremost desire is to make \$100,000 annually will not be content here in Marshfield.

We are not implying that there is anything wrong with making \$100,000 a year. (Except, that the tax bite hits too hard.)

But, here we have made a choice. We know we cannot have everything and \$100,000 salaries, too. So, we have chosen medical and economic security, the best of facilities and equipment and the staff and patients to practice *avant garde* medicine.

By many doctors' standards, we have some funny notions about compensation. Others agree they have thought the same for years, but often found their beliefs unpopular — especially with their superiors.

Long ago, investigation of many Clinic salary schedules told us that generally younger men were not being paid enough, that the older men were getting too much, and the middle group was getting about what it should.

At this Clinic we believe young men need not support any "senior partners". And they do not. The Clinic directors — all doctors who have been with us for two years or more — vote themselves their annual salaries. *All physicians regardless of specialty reach identical top salary in five years or less of their coming to Marshfield.*

Our rationale seems to appeal to many of those who are considering joining us. It is that each of us is as valuable as another to the patient, to human need and suffering. Here, to practice the best and most complete medicine possible, we need each other. We share equally in the Clinic's challenges, problems and rewards.

The doctor's wife and family will like the Clinic's health and retirement plan, vacation schedule, and other fringe benefits.

But the doctor won't consider joining us for any of those reasons alone.

An old timer — he's over 50 — went overboard recently and called the fringe benefits "best in America;" the retirement program — "sensational."

Our personnel people don't know if that's truth or fiction. They tell us though, that he's probably closer to being right than wrong. Consider the facts:

- Paid vacation: Begin with three weeks during the first year and progress to six weeks after age 60.
- Travel Expenses: \$1000 annually allowed for attending national, regional, or specialty meetings. (Meeting attendance not deducted from vacation time)
- Life Insurance: Up to \$75,000 for all physicians.
- Group Hospitalization and Dental coverage. For the physician and his family it is better than most any commercial plan.
- Complete professional liability insurance.
- Sick leave: Three months at full salary. Beginning the

91st day, insurance coverage provides \$1,000 monthly. After six months, insurance coverage provides an additional \$1,000 monthly, or a total of \$2,000 per month until the physician is rehabilitated, or until age 65. (This is in addition to what you may receive from social security.)

- Retirement: Maybe it is "sensational." The physician must retire at age 65 at about the same income as his salary. Or, he may choose retirement at 55 or 60.
- Estate planning.



Two golf courses are within minutes of the Clinic.

If it's expressways, huge shopping centers, the theater district, and very bright lights you seek, forget us.

We don't smell dirty air either. Or, see dirty water. Or drive 40 minutes to the hospital. Or wait in fear if our 16 year old daughter is walking home alone tonight after play practice.

Our guess is that the city of Marshfield (population 15,000) will neither attract nor repel the physician from afar. He will come to see the Clinic and the men practicing medicine here. But, he has basic demands of his habitat:

- He wants fine schools for the children. This city has been exceptionally responsible here, and our national honor scholarships, SAT scores, and fine, new physical plants show it.
- He would like it to be safe, clean, attractive. Marshfield is that.
- He wants to feel comfortable, stimulated, with the people around him in the community. Here he will meet academic, business, professional people — young and older — just as he would in most suburban communities.
- He wants a nearness to recreational outlets. How about a half mile ski run with tows? Or northern pike and musky waters? Or goose, duck and grouse shooting? Water skiing or sailing and snowmobiling? Golf at a public course or the country club which also has an indoor all-year pool? Everything is within 30 minutes of the Clinic. If he wants to see the Green Bay Packers play on Sunday or Big Ten Games in Madison on Saturday, it's a leisurely two and a half hour drive to either.
- Culture — the academic life? A two-year division of the University of Wisconsin is here in Marshfield. Thirty-five minutes away is Wisconsin State University - Stevens Point, with 9,000 students in both undergraduate and graduate programs. (Several Clinic wives are finishing degree requirements.) The same ballet troupes, symphony orchestras, touring theater groups that play Minneapolis, Milwaukee and Chicago, can be seen there.
- Shopping and a night in the big town — it's an hour's flight in scheduled turbo-jet commuter planes to both those big cities — Chicago and Minneapolis. Or, drive it in four to five hours.
- Living — would you believe forested acre lots, overlooking a river scene, go for under \$4,000 — only eight minutes from the Clinic? They do.

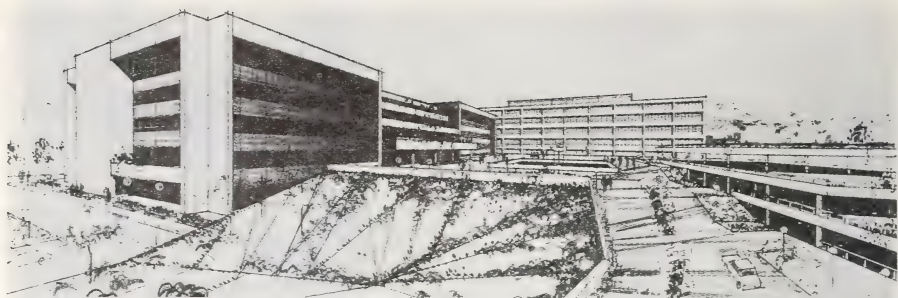
This we promise — no hard community sell. For the physician who wants to visit the Clinic and a wife who wants to visit Central Wisconsin, there will be hosts from this staff to answer their questions and show them the community. Fair enough?



Northern Wisconsin is nationally known as a fishing paradise.

Education at all levels is vital to Clinic people. A responsible Marshfield citizenry has provided for new physical plants from kindergarten through the college sophomore year. A Wisconsin State University of 9,000 students with both bachelors and masters degree programs is 35 minutes away.





One of four physicians will be intrigued with the realities of practicing medicine here. If you are that one doctor, will you come visit us?

We shall continue to provide the best medical care possible. We acknowledge that most patients cannot judge the quality of medical care, that in many instances medical care of lesser quality is more palatable to patients. We will work to make our superior medical care as attractive as possible to those patients.

We shall continue in every way to make the way of practicing medicine at the Marshfield Clinic as attractive as possible to the men working in the group. We will provide the best possible facilities and permit only those men in the group who can merit and maintain the respect of their colleagues.

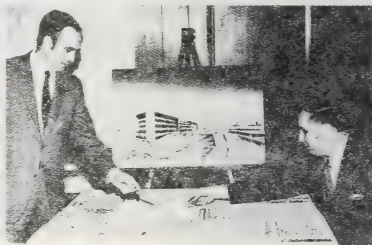
Presently we are constructing a new Clinic building. With 117 doctors today, a need for 130 tomorrow, and possibly 150 the day after tomorrow, we must be prepared to offer the patient service demanded of us from the area we serve, an area of over 10,000 square miles and one million people.

Several U. S. Secretaries of Health, Education, Welfare have been at the Clinic with us. We visualize more streamlined patient handling, while preserving human dignity in patient care. We will enlarge our residency program, expand our computer linkage with the HEW memory bank in Washington on one hand and smaller Clinics and hospitals in Wisconsin on the other.

If dreams such as these excite you, too, as they excite us, then you may well be the one in four doctors we want to join us; and who will find the medical practice he seeks at a Clinic we believe is targeted for greatness.

We invite you, then, to visit us and find out.

James M. Ensign, Clinic Executive Director, and David R. Jaye, President of St. Joseph's Hospital discuss the plans for the medical center.



A new \$25 million medical center will be one of the finest of its kind in rural America.

These Are The "ONE IN FOUR" Who Make Up The Team At The MARSHFIELD CLINIC

ANESTHESIOLOGY

John L. Burns, M. D.
John W. Gildersleeve, M. D.
Warren J. Holtey, M. D.
Warren L. Miranda, M. D.
Donald P. Pederson, M. D.
Pandy G. Swamy, M. D.

AUDIOLOGY

Richard Strand

CARDIOVASCULAR & THORACIC SURGERY

Ben R. Lawton, M. D.
William O. Myers, M. D.
Jefferson F. Ray, III, M. D.
Richard D. Sautter, M. D.

CLINICAL PSYCHOLOGY

Harold J. Fahs, Ed. D.
Rodney D. Freeborg Ph. D.
Merril W. Hergert, Ph. D.
James R. Kiland, Ph. D.
Torberg P. Nordmark, Ph. D.

DERMATOLOGY

Stephen I. Hegedus, M. D.
Richard J. Rowe, M. D.
William F. Schorr, M. D.

FAMILY MEDICINE

Joan M. Barrett, M. D.
E. Grady Mills, M. D.
John H. Mitchell, M. D.

GENERAL SURGERY

Charles P. Floyd, M. D.
Gary F. Gilbertson, M. D.
Jerry M. Hardacre, M. D.
Gail H. Williams, M. D.

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William J. Maurer, M. D.
Michael P. Mehr, M. D.
James L. Struthers, M. D.

Allergy

Raymond L. Hansen, M. D.
Robert M. Heywood, M. D.

Cardiology

John N. Browell, M. D.
Dean A. Emanuel, M. D.
Fred W. Fletcher, M. D.
F. John Gouze, M. D.
George S. Strauss, M. D.
Richard H. Ulmer, M. D.
Dieter M. Voss, M. D.

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Francis N. Lohnenz, M. D.
Richard W. Miller, M. D.
Thomas F. Nikolai, M. D.

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Sidney E. Johnson, M. D.
Robert G. Norfleet, M. D.
J. Francisco Nunez, M. D.
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John B. Wyman, M. D.

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Edward W. Walters, M. D.

Nephrology & Hypertension

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Wladyslaw Z. Zurek, M. D.

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Anthony J. Waisbrot, ACSW

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Nelson A. Moffat, M. D.
Michel Y. Roy, M. D.

Senator NELSON. If the members of the committee have any additional questions for either of you or Mr. Nycz, I assume you would be prepared to respond to them in writing for the hearing record?

Dr. LAWTON. Yes, Senator.

[Additional material submitted by Dr. Lawton follows:]

A PILOT STUDY COMPARING
THE UTILIZATION AND HEALTH CARE COSTS INCURRED
BY GROUP AND NONGROUP ENROLLEES
OF A PREPAID GROUP PRACTICE

Conducted by
The Marshfield Medical Foundation
Marshfield, Wisconsin

Principal Investigator
Ingo Angermeier

SUBJECT: IMPACT OF OPEN ENROLLMENT MEMBERS OF A PREPAID GROUP PRACTICE ON UTILIZATION AND COST OF PROVIDING CARE.

TITLE: A PILOT STUDY COMPARING THE UTILIZATION AND HEALTH CARE COSTS INCURRED BY GROUP AND NONGROUP ENROLLEES OF A PREPAID GROUP PRACTICE.

AUTHOR: INGO ANGERMEIER

CONTRACTOR: Marshfield Medical Foundation
Marshfield, Wisconsin

CONTRACT OFFICER: Frederick J. Wenzel
Executive Director

PURPOSE OF THE STUDY: To demonstrate the effects of an open enrollment on the utilization of plan benefits and the cost of providing those benefits; to provide an empirical base line describing the effects of nongroup enrollees for plans contemplating instituting a policy of open enrollment.

METHOD USED: Utilizing the data files of the Clinic, all enrollees of the Greater Marshfield Community Health Plan were categorized according to group and nongroup status. They were then placed into frequency distributions describing outpatient utilization, inpatient utilization, cost of outpatient care, cost of inpatient care, and total health care costs incurred. These distributions were tested to determine whether the observed distributions corresponded to expected experience. A second study similar in structure to the first was undertaken describing only those group and nongroup enrollees with at least six months experience in the plan prior to the study year.

SIGNIFICANT FINDINGS AND CONCLUSIONS: Compared to group enrollees of the total plan, nongroup members have higher utilization and health care costs. The difference in the health care behavior between group and nongroup enrollees with prior experience is less than that of the total plan. It is not prohibitive for the GMCHP to provide benefits to nongroup enrollees.

RECOMMENDATIONS: The GMCHP should continue to practice its policy of open enrollment. This study should be taken as a base line describing one plan's experience with nongroup enrollees and may encourage other plans to consider such a policy.

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CHAPTER I

INTRODUCTION

A - Background Information

The health care delivery system of the United States has been the subject of increasing scrutiny by health care professionals, public lawmakers, and the consumers of health care. Much dissatisfaction has been expressed over discontinuity of care, inconsistent quality of care, and poor accessibility--all in the face of rapidly rising costs.

The recent development of Health Maintenance Organizations (HMOs) has been hailed by many as the savior of the American health care delivery system. HMOs are generally thought to be organizations contracting directly with consumers to provide a comprehensive package of health care services at a fixed price to the alleged end of maintaining health as opposed to active disease treatment. The number of definitions of what an HMO is and does is matched only by the number of organizations claiming to practice health maintenance.

In spite of their widely varying organizational structures and benefit packages, proponents of HMOs insist on comparing

their utilization rates and hospital inpatient days to both each other and the alternative fee-for-service system. The publications they generate extolling their merits bulge with statistics claiming that emphasis on preventative outpatient care has lowered hospital inpatient utilization to less than half the national average.¹

However, should not the HMO compare utilization rates of like populations for any such comparisons to be valid? Few HMOs allow enrollment for those over 65. Few HMOs provide services to those on Medicaid. Few HMOs open their enrollment to those that are not members of an employee or union group. Most of those that do require physicians to eliminate coverage for pre-existing conditions or require security deposits. While HMOs experience lower rates of hospitalization than the national average, it remains unclear whether they do so as a result of their emphasis on maintenance or as a result of their enrollment selectivity. Until such time as these prepaid group practices can demonstrate their claims of lower utilization and greater cost effectiveness on the population at large, their claims of efficiency will remain questionable.

If current legislation is any indication of lawmakers preferences, prepaid group practices will be increasingly en-

1. I. S. Falk, "Prospects for Prepaid Group Practice," American Journal of Public Health, Vol. 59 (January, 1969.)

couraged to open their enrollment policies. As of 1973, eight of the twelve states which have enacted HMO legislation are requiring some form of enrollment beyond closed employee groups. These laws indicate that prepaid group practices must open their enrollments at least somewhat after a given length of developmental time--usually two years.

The "Health Maintenance Organization Act of 1973" sets the guidelines for a federally certified HMO. Section 301.4 of this act states that an HMO must "have an open enrollment period of not less than 30 days at least once during each consecutive twelfth month period during which enrollment period it accepts, up to its capacity, individuals in order in which they apply for enrollment, . . ."² It is becoming increasingly more clear that for HMOs to continue their popularity as a viable alternative to the existing health care delivery system, they must open their enrollments to serve the entire populus.

B - Purpose and Scope of this Study

This study is being undertaken to demonstrate the effects (or lack thereof) of an open enrollment on the utilization and costs of providing care in a prepaid group practice. For prepaid plans to fairly justify their claim as a low cost alternative health care

2. Health Maintenance Organization Act of 1973, (Washington Government Printing Office, Washington, D. C., 1973.)

delivery system, they must do so by servicing a cross section of the population.

C - Review of the Literature

A review of the literature describing group and nongroup experience in the HMO setting does more to demonstrate the need for further study in the area than shed much light on the topic. This is due largely to the fact that few, if any, other HMOs open their enrollments to a population at all comparable to the total population.

In contrast to their reluctance to provide services to the entire population, the proponents of many of these prepaid plans compare their rates of utilization of care to that of the general public or some other incomparable group of consumers.³ Such comparisons are invalid largely because of the selection process of those considered eligible for the plan. Some examples of

-
3. Ray Bloomberg, "Group Practice Hospital: How Seattle Plan Works, How Doctors are Paid," Modern Hospital, Vol. 112 (May, 1969.)

Gunnar Fredriksen, "HMO's: New Horizons or Organizational Nightmares?" Hospital Progress, Vol. 53 (April, 1972), p. 44.

Gordon K. MacLeod and Jeffrey A. Prussin, "The Continuing Evolution of Health Maintenance Organizations," New England Journal of Medicine, Vol. 288 (March 1, 1973), p. 442.

Greer, Williams, "Kaiser: What is it? How Does it Work? Why Does it Work?" Modern Hospital, Vol. 116 (February 1971), p. 78 & 83.

eligibility requirements used to "weed out" alleged high risk groups include employment with an acceptable group, a pre-enrollment physical to screen pre-existing conditions, a large initial capital investment, or ownership of a home. "These medical care systems (HMOs) cater essentially to the working populations. The socioeconomic population distribution is truncated because the very poor and the wealthy are not included. Particularly if poor populations are excluded, HMOs are not likely to have the widespread significance in solving the problems in universal access to medical care."⁴

A study completed by Densen, Shapiro, and Einhorn confirmed that high utilizers of care tend to remain high and low utilizers of care tend to remain low. While no attempt is made in the study to correlate high utilization with socioeconomic characteristics, the work implies such a relationship. A drawback of the study is that no attempt is made to correlate utilization with cost of providing care.⁵

4. Ernest Saward and Merwyn R. Greenlick, "Health Policy and the HMO," Milbank Memorial Fund Quarterly, Vol. 50 (April, 1972), p. 169.

5. Paul M. Densen, Sam Shapiro, and Marilyn Einhorn, "Concerning High and Low Utilizers of Service in a Medical Care Plan, and the Persistence of Utilization Levels Over a Three Year Period," Milbank Memorial Fund Quarterly, Vol. 37 (July, 1957), p. 217. ✓

Research by Greenlick, Freeborn, Colombo, Prussin, and Saward compares the utilization of medical care services by the general membership of a prepaid group plan to that of an OEO Comprehensive Neighborhood Health Center program. Findings from the study are, however, non-generalizable to the total public in that the selection criteria for the OEO population included families with specific known health problems requiring attention.⁶

A research report conducted by Dr. Robert L. Peterson comparing inpatient and outpatient utilization of like populations concluded that inpatient hospital admission rates are generally lower for prepaid group practice enrollees than for comparable holders of private insurance policies. While the results of this study are conclusive, the groups involved again do not represent a cross section of the population.⁷

While these and other studies describing how prepaid group practices affect the utilization rates of their enrollees are useful, they do not describe a situation where care is provided to a cross section of the population. "What is regarded as the crucial test

6. Merwyn R. Greenlick, Donald K. Freeborn, Theodore J. Colombo, et al, "Comparing the Use of Medical Care Services by a Medically Indigent and a General Membership Population in a Comprehensive Prepaid Group Practice Program," Medical Care, Vol. 10 (May-June, 1972), p. 187.

7. Robert L. Robertson, "Comparative Medical Care Use Under Prepaid Group Practice and Free Choice Plans: A Case Study," Inquiry, Vol. 9 (September, 1972), p. 70.

for the prepayment, capitation, group plan would be its record in serving these segments of the population usually excluded from medical plans restricted to the gainfully employed. There is a lively curiosity about how a prepaid plan would fare with a low income group."⁸

Another important issue is the extent to which congressional action will force some form of community rating on HMOs. It seems far better for this issue to be resolved in the context of national health insurance legislation than in statutes pertaining to HMOs. If HMOs are forced to community rate all or large numbers of their enrollees, such a constraint can only be viewed as a severe hindrance to their development and expansion, particularly if open enrollment is required.⁹

This study will compare the health care experience of group and nongroup enrollees in a community-rated prepaid group plan who are comparable to the fee-for-service population of the same area.

D - Definition of Terms

Listed below are definitions of certain terms which will be referred to throughout the text of this paper. These definitions are meant to lend continuity to this study and may or may not correspond with definitions found elsewhere.

8. "Prepaid, Capitation, Group-Practice Plans of Health Care Including Health-Maintenance Organizations," New York State Journal of Medicine, Vol. 71 (September, 1971), p. 2211.
9. Robert D. Eilers, "The Implications of HMO's for Private Insurers," Inquiry, Vol. 10 (March, 1973), p. 62-63.

Greater Marshfield Community Health Plan (GMCHP): GMCHP is a prepaid group practice health plan sponsored by the Marshfield Clinic, St. Joseph's Hospital, and Wisconsin Blue Cross-Surgical Care Blue Shield. The plan is described as an HMO offering a comprehensive range of benefits for a fixed monthly fee with emphasis on the elimination of barriers toward receiving maintenance type care.

Eligible Population: The population eligible for enrollment in GMCHP is any person or persons under age 65 who live and/or work in Marshfield or 30 defined contiguous townships surrounding the Marshfield area. (See appendix A for map of the Greater Marshfield Community Health Plan area.)

Group Member: A group member is an enrollee in GMCHP who enters the plan within a block of five or more contracts. This block is a group of persons associated for some purpose other than the sole ends of purchasing insurance.

Nongroup Member: A nongroup member is an enrollee in the Greater Marshfield Community Health Plan who contracts directly with the plan for either himself or his family.

Community-Rating: Community-rating is the setting of an insurance charge based on the experience of the entire eligible

population. All insurees are charged the same contract rate irrespective of their place of employment, past insurance experience, or present medical condition.

Experience-Rating: Experience-rating is the determination of an insurance charge which varies within the insured block according to some predetermined parameters. The GMCHP offers only a community rate in that all plan participants, whether group or nongroup, are charged the same contract rate.

Open Enrollment Period: An open enrollment period is a designated length of time during the year when any eligible person or persons may join the GMCHP. Nongroup enrollees must enroll during such periods while group contracts are accepted at any time. This is done to protect the plan from those who would enroll with the intent to satisfy some known, significant medical problem.

Encounter: An encounter is an ambulatory contact between the patient and the provider of health care. "Provider refers to a physician, oral surgeon or other person primarily responsible for assessing the condition of the patient, for exercising independent judgement as to the care of the patient, and for

services rendered for a given encounter."¹⁰ Physician assistants, nurse practitioners, speech therapists, and audiologists may be considered as providers of care.

Because the Marshfield Clinic does fill out encounter forms, encounters have been approximated from computer records of patient registrations. One patient seeing one provider on one day is tallied as one encounter. One patient seeing three providers on one day is tallied as having three encounters. Laboratory tests and X-ray procedures are assigned to the provider ordering the tests. If no face-to-face contact occurs between the patient and the provider ordering the tests, an encounter is tallied for the procedure because it represents the expenditure of a health care resource. If such contact should occur, the tests are included with the contact encounter and only one encounter is tallied. Encounters are tallied for ambulatory contacts where no charge is made.

Inpatient Days: Inpatient days are the number of days of service rendered on an inpatient basis counted from the day of admission to the day before discharge.

10. Guidelines for Producing Uniform Data for Health Care Plans, (DHEW Pub. No. HSM 73-3005, 1972), p. 34.

Cost of Providing Care: The cost of providing care is that amount of resources (expressed in dollars) expended by the GMCHP in providing its enrollees with contracted benefits during a given period. For purposes of this study, the cost of providing care is approximated according to the limitations defined in Chapter II.

E - Clinic Setting

The Marshfield Clinic was founded as a multispecialty group practice in 1916 by six physicians. From this group has developed the present organization of 120 physicians representing 26 specialty and subspecialty departments. In the year 1973, the Marshfield Clinic had 212,014 registrations.

On March 1, 1971, the Clinic, in conjunction with St. Joseph's Hospital and Wisconsin Blue Cross-Surgical Care Blue Shield, began serving patients under the Greater Marshfield Community Health Plan. Negotiations between the three parties sponsoring the plan had been underway approximately one year prior to the plan's opening. (See Appendix B for an organizational chart of the GMCHP.)

Two objectives of the plan were "to establish the cost of high quality medical care in this type of program in rural Wisconsin, and to make the same comprehensive care available to all citizens within the Greater Marshfield area." In line with

the first objective, plan benefits were made as comprehensive as practical. (See Appendix C for provisions of the Greater Marshfield Community Health Plan.) Meeting the second objective involved opening the plan's enrollment to individual community members as well as employee groups. Individual enrollees are treated exactly as group members of the plan. No one receives a pre-enrollment physical to screen for pre-existing conditions; no initial deposits are required; and all enrollees are charged the same monthly contract rate.

Enrollment in the GMCHP has grown from 9,848 participants in January of 1972 to over 17,500 two years later. This represents approximately 40 percent of the population eligible for the plan.

Because of the large referral nature of the Marshfield Clinic, the GMCHP represents less than 12 percent of the gross income of the Marshfield Clinic.

In the fall and winter of 1973, the GMCHP expanded its target area to include two contiguous counties, Clark and Taylor. Experience from these affiliated plans will not be included in this study due to their presently small enrollments.

If anticipated income would motivate a physician's regime of treatment, the fee-for-service patient may tend to be "over-treated" while the GMCHP patient would receive less

care. However, all providers of care at the Marshfield Clinic are salaried employees. Further, from the outset of the plan, Clinic physicians indicated a preference toward treating plan members in the same manner as fee-for-service patients. To facilitate this, physicians are given no information regarding any patient's method of payment. The Marshfield Clinic physicians do not know whether or not the patient they are treating is a member of the GMCHP. (An unpublished report completed by Joel Broida confirmed this.) The utilization rates and corresponding costs of providing care presented in this study compare group and nongroup experience ordered by a physician whose actions are not guided by knowledge of the patient's method of payment.

F - The Hypotheses

The Greater Marshfield Community Health Plan serves a population which has been shown to represent a true cross section of the total population of the same area. Most operating HMOs limit their enrollment to include only low risk employee groups. Since lawmakers are encouraging prepaid health plans to broaden their eligibility requirements, a comparison of the GMCHP's experience with providing care to group and nongroup enrollees may be helpful to plans broadening their eligibility requirements to include nongroup enrollees.

The primary hypothesis of this study is that the utilization

and cost of providing health care to nongroup enrollees of the GMCHP does not differ significantly from the experience of the group enrollees. This notion leads to several secondary hypotheses to be tested. Briefly stated, these are that the nongroup enrollees, compared to the group members, will incur: 1) the same rate of outpatient encounters; 2) the same number of inpatient days; 3) the same costs for outpatient services; 4) the same costs for inpatient care; and 5) the same costs for total health care services provided.

CHAPTER II

METHODOLOGY

A - Study Design

In order to describe the GMCHPs group and nongroup experience in detail, percentage frequency distributions of group and nongroup enrollees were generated. These distributions categorized enrollees by number of encounters, number of inpatient days, and dollar intervals describing cost of outpatient care, inpatient care, and total health care costs. This study will include data from all persons enrolled and active in the plan from July 1, 1972 through June 31, 1973.¹ A full year cycle is chosen to eliminate seasonal variations in the utilization of health care. The specific year chosen for this study represents a time period during which the capitation rate paid the Clinic and per diem rate paid the hospital remained the same. Enrollee subscription fees were also constant.

1. To simplify data collection and display, the experience of persons entering or exiting the plan during the study year will not be included.

The use of encounters as a measure of outpatient utilization carries with it certain limitations which must be noted. The definition of encounter usually varies from one institution to another. Often it is described as a face-to-face contact between an enrollee and a physician. Using this definition, the degree to which various plans utilize paramedical personnel can become important. For purposes of this study, the definition of encounter is meant to reflect some measure of the number of ambulatory health care resources expended by an enrollee (see page 9 for GMCHPs definition of encounter.) In light of potential discrepancies between what various plans define as an encounter, care must be taken in comparing GMCHPs outpatient encounter rate to that of other plans. However, insofar as encounters are tallied in the same manner for group and nongroup enrollees within this study, the relationship between the group and nongroup experience should be of value.

The method of tallying enrollee inpatient days is a bit more straightforward and universal among prepaid plans. Comparison to the GMCHPs experience is, however, subject to the limitation of its broad eligibility requirements for enrollment.

Besides comparing the utilization rates of group and nongroup enrollees, the costs of providing care to these units will be described. Because of the aforementioned difficulties in-

volved in the comparison of encounter rates, the costs of providing these outpatient services will be compared for the two units. Subject to the limitations of the costing method used, this comparison should reveal in terms of dollars how many more or less health care resources must be applied to the nongroup members of the GMCHP.

A comparison of the costs of providing inpatient care to group and nongroup enrollees includes both the costs of hospitalization, and the cost of physician services related to hospitalization. The hospital costs of the plan are computed by multiplying the number of inpatient days experienced times the per diem rate paid the hospital (\$90.00 per person per day during the time of this study.) The cost of physician services related to inpatient hospitalization is an approximation of the resources expended by the Clinic subject to the limitations described in Section D of this chapter.

The last frequency distribution describing the total costs of providing prepaid health care to group and nongroup enrollees is a summation of the above two.

B - Study Approach

The initial portion of this study describes one year's experience of the GMCHP with its group and nongroup enrollees beginning July 1, 1972. Since the plan began offering its benefits

on March 1, 1971, the findings of this study would reflect the experience of a relatively new prepaid plan with its open enrollment.

A major fear of plans contemplating an open enrollment as is present in the GMCHP is the notion that nongroup enrollees may join to satisfy some large, known, unmet medical need. Assuming that this phenomenon does occur to some extent, it would seem logical to conclude that as these health care needs are satisfied, the phenomenon will occur to a lesser degree in each succeeding open enrollment period. The open enrollment period will work to deplete this pool of unmet health care needs.

This study depicts the GMCHPs experience with nongroup enrollees during the relative infancy of the prepaid plan. The degree to which the above described phenomenon will affect the findings of the initial portion of this study is unknown.

In attempt to adjust for the alleged occurrence of this phenomenon, a second study will be undertaken with a format identical to the initial work. This study will focus on only those group and nongroup members enrolled in the GMCHP at least six months prior to the beginning of the study (i.e. January 1, 1972.) By studying this experienced subpopulation of the total plan, it is expected that the pool of unmet health care needs will have been largely satisfied prior to the study year.

It is also anticipated that this portion of the study will more closely approximate the group and nongroup experience of a more maturely developed prepaid group practice than the GMCHP. This subgroup study will test the same hypotheses as the total plan study.

If it is true that there is an initial level of high utilization, as unmet needs are discharged, the experience of the group and nongroup enrollees should be more similar in the second portion of the study.

C - Limitations

The findings obtained from this study are limited in their universal applicability by certain characteristics which may or may not be unique to the Greater Marshfield Community Health Plan. The sampling involved in this study are all those enrollees of the GMCHP who were active from July 1, 1972 through June 30, 1973. Anyone under age 65 living or working in the defined thirty township area surrounding the city of Marshfield was eligible to join the plan. (See Appendix A for a map of GMCHP area.) Approximately 25 percent of the total enrollment of the plan consists of nongroup members who entered during an open enrollment period.

Approximately 40 percent of the under 65 area population is enrolled in the plan. A study was undertaken by Harry Sharp, PH. D.

for the Marshfield Clinic Foundation for Medical Research and Education to compare the socioeconomic characteristics of the population enrolled in the GMCHP to area residents under 65 not enrolled in the plan. His work indicated that the socioeconomic characteristics of the population enrolled in the plan are essentially the same as the fee-for-service population of the same area.²

The presence of the Marshfield Clinic employees and their families as well as certain other groups are factors which must be considered in the interpretation of the findings of this study.

Employees and their families of the Marshfield Clinic and St. Joseph's Hospital, Marshfield, Wisconsin, are both units described in this study as group enrollees. Their sophisticated knowledge of the health care system makes them less reluctant to utilize health care. Their presence in this study works to some degree to "inflate" the utilization and cost data of groups enrolled in GMCHP. As of July, 1973, Clinic and hospital enrollees in the plan numbered 1,942 and 2,318 respectively (approximately 28 percent of the total enrollment.)

2. Harry Sharp, "An Analysis of the Greater Marshfield Community Health Plan Terminations," Marshfield, Wisconsin (an unpublished report done for the Marshfield Clinic Foundation for Medical Research and Education, Inc., 1973), p. 78.

Another factor which may influence the results of this study is the variable percentage of GMCHP premium paid by the employer for his group units and any resulting psychological effect on utilization. Most employers of groups in the plan pay over 50 percent of their employees' premiums. A commonly held, though unproven, assumption holds that the more a person pays "out-of-pocket" towards his care, the more likely he is to use that care. Everyone wants to get their money's worth. A large unit included with the group data of this study are the dairy farm cooperative groups (2,612 participants in July of 1973.) These dairymen "group" themselves according to where they sell their products. Their association does not contribute towards the payment of GMCHP premiums. The degree to which this effects their utilization of plan benefits is not known, though it is suspected this group may behave more as a nongroup.

The presence of health care-related groups and dairy cooperative "nongroup groups" in the group data of this study may to some degree be offsetting. Further study would be needed to determine how each of these units affects the utilization and cost of providing care of group enrollees in GMCHP.

The method used to determine the cost of providing services to prepaid plan participants may also affect the findings of this study. The Marshfield Clinic does not determine its plan

costs according to each procedure performed or service provided. For purposes of this study, the costs of providing care to plan participants will be approximated as a percentage of what would be charged for the same procedures on a fee-for-service basis. This percentage was determined by subtracting the cost of credit and collections and cashiers departments, provision for discounts and allowances, and profits realized from Clinic operating expenses during the year. The costs associated with these areas are thought to represent resources not applied to Greater Marshfield Plan participants.

While discounting charges for an individual procedure in this manner would not necessarily reflect that procedures cost, subtracting these budgetary items from the Clinic's total yearly charges closely approximates total plan costs. The accuracy or validity of this method of cost finding is an issue beyond the scope and intent of this study.

D - Method of Data Collection

The data for this study were obtained from computerized files summarizing monthly charges posted to patient accounts. These files are maintained for billing purposes on all patients receiving care at the Marshfield Clinic irrespective of their method of payment. Because GMCHP patient accounts are tallied in the same manner as fee-for-service accounts, the data obtained from these files are considered to be accurate.

E - Statistical Testing

Most statistical studies involve the gathering of certain descriptive summaries from a randomly gathered sampling of a general population. Various statistical tests are performed on that data. If all the assumptions of the model are fulfilled and the sampling gathered is indeed random, certain inferences can be made from the sampling to the general population which hold true with a known probability. Because this study utilizes data describing all enrollees of the GMCHP during the given period, no inferences from any subset thereof are made to the general population. Conceptually then, this study describes the total GMCHP population as opposed to inferring generalizations from tests performed on a random sampling of that population.

The statistical tests which will be used to accept or reject the stated hypotheses will be chi-square, goodness of fit. Frequency distributions will be generated comparing group and nongroup plan experience according to the five categories described. Observed frequencies of occurrences in each grouping of a frequency distribution will be compared to expected values. Expected frequencies will be determined by multiplying the sum of group and nongroup experience in a class by the proportion of group and nongroup enrollees in the plan.

Because small hypothetical frequencies may distort the findings, where expected values fall below 5 for any class, classes of data will be grouped.³

3. Jerome C. R. Li, Statistical Inference, (Edwards Brothers, Inc., Ann Arbor, Michigan, 1964), p. 494.

CHAPTER III

ANALYSIS OF THE DATA

The findings of the study relating to the five hypotheses to be tested on both the total enrollment of the GMCHP and the described subpopulation will be summarized together. Each section will include a statement of the hypothesis, the calculated test statistic, the corresponding degrees of freedom, a graph depicting the data gathered, and a table summarizing the experience of both the total GMCHP and the experienced subgroup.

A - Outpatient Encounters

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of encounter."

A frequency distribution was generated whereby group and nongroup enrollees in the GMCHP were categorized according to the number of encounters they experienced during the study period. The statistical test of choice to compare the experience of the group and nongroup enrollees is chi-square goodness of fit (χ^2).

Application of this test to the generated frequency distribution involved the determination of hypothetical expected frequencies for each category. For example, 1,606 group enrollees experienced one encounter during the study year compared to 451 nongroup members of the plan. Since a total of 2,057 plan members experienced one encounter, it can be expected that the number of these which were group and nongroup enrollees is proportional to the total group to nongroup enrollment during the study year. Since group enrollment represented 76.4 percent of the total enrollment of the plan, it could be expected that 76.4 percent of those enrollees experiencing one encounter, would be group members. The expected number of group enrollees experiencing one encounter is then 2,057 times .764 or 1,571.5 enrollees. The expected values of all classes of data in this study were computed in this manner. (See Appendix D for a sample of the chi-square goodness of fit computation.)

The one-sided statistical test was performed on the group and nongroup frequency distributions describing the number of encounters experienced during the study year by persons within the respective units. The test was performed at the significance level of .05. The resulting test statistic value of 42.25 was more than the critical value of 37.652 at 25 degrees of freedom.¹

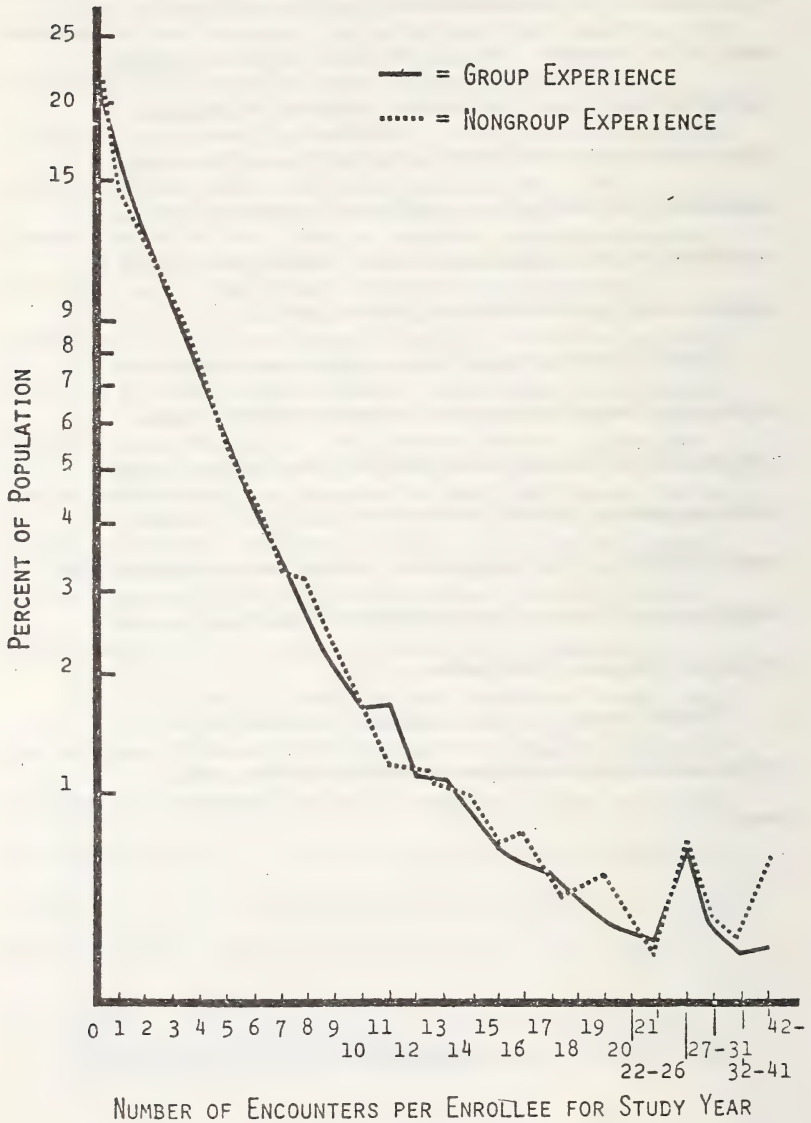
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1. Richard D. Remington and M. Anthony Schork, Statistics with Applications to the Biological Sciences, (Prentice-Hall), Table A-6, p. 376.

Based on the relative frequency of the total population of the GMCHPs encounter rate, one can expect two randomly gathered distributions to be more dissimilar than the two observed less than .025 of the time. The hypothesis is therefore rejected. During the study year, the relative frequency of encounter rates realized by group enrollees of the Greater Marshfield Community Health Plan was significantly different from the experience of the nongroup enrollees. (See Appendix E for a sample of the hypothesis testing method used.)

Graph I (see next page) shows a frequency distribution of group and nongroup enrollees by their encounter rates. The graph uses percent of the group and nongroup unit population as opposed to their raw numbers in order to overlay their experience. The comparison is drawn on semi-logarithmic paper in order to more clearly depict the experience on the tail of the frequency distribution.

Table I compares some summary statistics on the group and nongroup outpatient experience for the study year.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY FREQUENCY OF ENCOUNTER



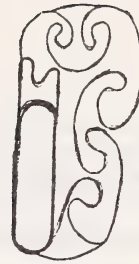


Table I

Comparison of Group and Nongroup Outpatient Encounters

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
No. of Encounters	38,603	75.0	12,871	25.0	51,474
(Subgroup)	32,073	76.6	9,822	23.4	41,895
Encounters/Enrollee	3.813		4.106		3.882
(Subgroup)	3.831		4.226		3.917

As can be seen from the table, while the nongroup enrollees represent 23.6 percent of the enrolled population, they account for 25.0 percent of all encounters. The nongroup subpopulation with at least six months experience prior to the study year, represent 21.7 percent of the total subpopulation while accounting for 23.4 percent of the total encounters.

The average number of encounters experienced per person during the study year was 3.882. The nongroup enrollees experienced an average of over .2 encounters per year more than this with a rate of 4.106. It is interesting to note that the nongroup subpopulation with more experience in the plan realized the highest mean encounter rate of 4.226 encounters per person per year. A comparison of the mean yearly encounter

rate of all group enrollees with the ambulatory utilization rate of the more experienced subgroup shows little difference.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees in the subpopulation have the same set of relative frequencies of encounter."

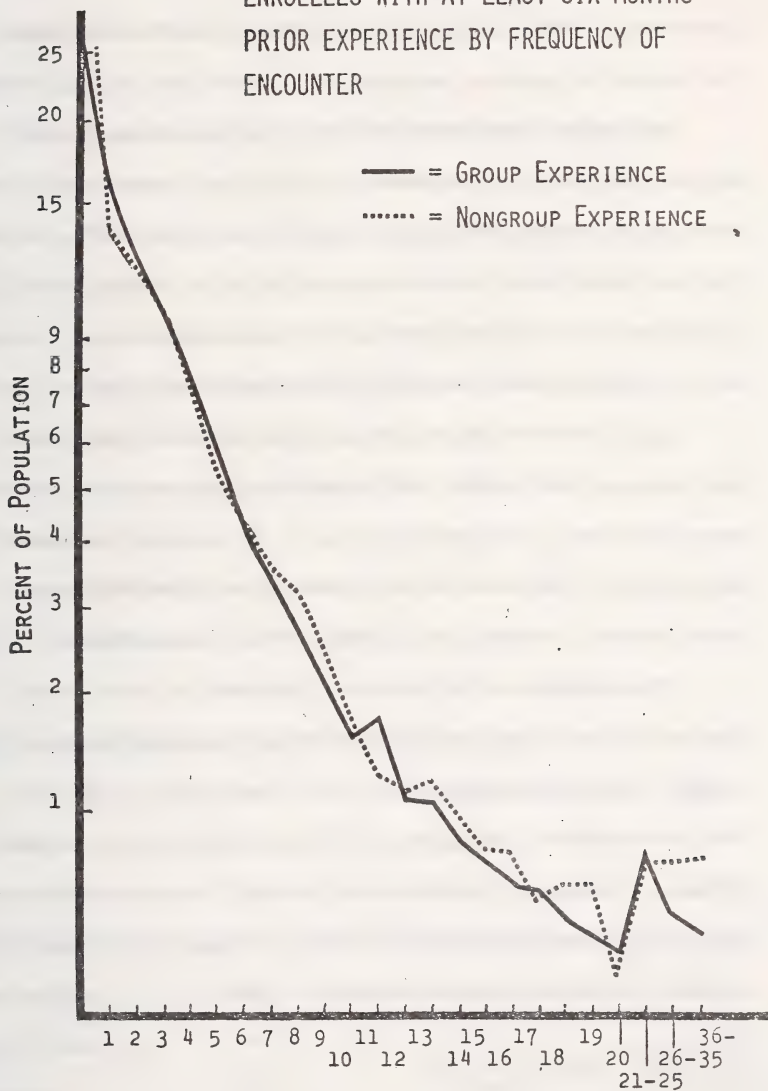
Application of the chi-square goodness of fit test to the frequency of encounters incurred by these group and nongroup subpopulations of the total study yielded a test statistic value of 30.95 at 22 degrees of freedom.² Since this is less than the defined critical value of 33.924,³ the hypothesis is accepted. That is, the encounter distribution is independent of type of enrollment.

Graph II (see next page) displays a percentage distribution of group and nongroup enrollees with experience in the plan by outpatient encounter. As in Graph I depicting ambulatory utilization for the total population, most of the variance between the group and nongroup utilization of ambulatory services occurs with persons experiencing ten or more ambulatory visits during the study year.

2. See Appendix F for a summary of this and all subsequent chi-square test results.

3. Remington and Schork, Table A-6, p. 376.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY FREQUENCY OF
ENCOUNTER



NUMBER OF ENCOUNTERS PER ENROLLEE FOR STUDY YEAR

B - Inpatient Utilization

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of inpatient days."

A frequency distribution was generated classifying group and nongroup enrollees experiencing hospital days during the study year according to how many days they were hospitalized. Tallying areas ranged from one hospital day to 49. Those hospitalized more than this amount were grouped as having experienced 50 or more hospital days during the study year.

Again, the chi-square goodness of fit test was applied to the frequency distribution. The hypothetical expected values were calculated in the same manner as in the encounter analysis. Hospital days experienced during the study year beyond 10 days were grouped to maintain the accuracy of the statistical test.

The application of the chi-square goodness of fit test to the inpatient utilization experienced by group and nongroup enrollees yielded a test statistic value of 27.34. Since grouping of the data was indicated by the small number of persons experiencing beyond 10 days, 12 degrees of freedom were allowed. The test statistic value was greater than the critical 21.026.⁴ Based on the total inpatient utilization experience of the GMCHP during the study

4. Ibid., Table A-6, p. 376.

year, one can expect two randomly gathered samplings to be more dissimilar than the actual group and nongroup experience observed less than .01 of the time. The stated hypothesis is therefore rejected.

Graph III (see next page) displays a percentage distribution of group and nongroup hospital utilization for the total study population. The graph is made on semi-logarithmic paper to amplify experience at the tail of the distribution. As the graph indicates, a smaller percentage of the nongroup unit experienced less than six days hospitalization than of the group unit. However, beyond six days, the nongroup enrollees utilize proportionally more inpatient days than corresponding group members.

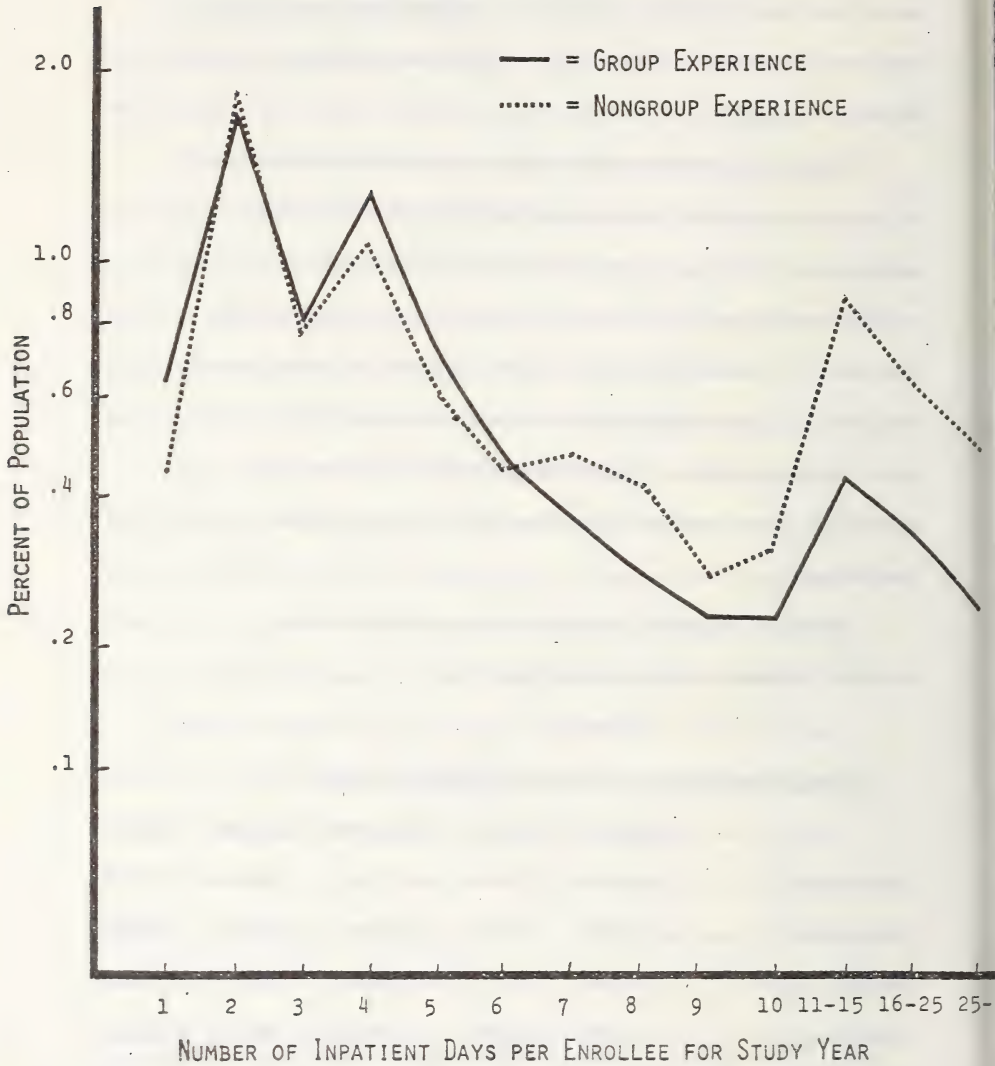
Summary statistics comparing group and nongroup inpatient utilization are found on Table II.

Table II

Comparison of Group and Nongroup Inpatient Days

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Hospital Days	5,044	66.9	2,494	33.1	7,538
(Subgroup)	4,206	69.9	1,815	30.1	6,021
Hospital Days/1000	498.2		795.5		568.5
(Subgroup)	502.3		780.9		562.8

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY FREQUENCY OF INPATIENT DAYS



In the total population study, nongroup enrollees represent 23.6 percent of the total GMCHP population while accounting for 33.1 percent of all inpatient days utilized. During the study year, the nongroup unit experienced 795.5 days of hospitalization per 1000 population--almost 300 more than group enrollees.

The subgroup study of enrollees with six month's prior experience yielded less dramatic differences. The 21.7 percent nongroup population accounted for 30.1 percent of the inpatient days experienced. Compared to the total population, the group enrolled subpopulation experienced 3.1 per 1000 population more inpatient days than the group enrollees of the total population. Conversely, nongroup enrollees with prior experience in the plan, utilized nearly 15 hospital days per 1000 less than the nongroup enrollees in the total population.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees have the same set of relative frequencies of inpatient days."

The frequency distribution of inpatient utilization was gathered and analyzed in the same manner as the data from the total population study. Application of the chi-square goodness of fit test yielded a test statistic value of 17.25. At 11 degrees of freedom, this is less than the critical value of 19.675.⁵

5. Ibid., Table A-6, p. 376.

The P-value associated with the test statistic is greater than .10 and the hypothesis is accepted. That is, the distribution of inpatient days is independent of type of enrollment.

Graph IV (see next page) compares the inpatient utilization of group and nongroup enrollees within this subpopulation. As in Graph III depicting the hospital utilization of the total plan, the proportion of the group and nongroup population experiencing less than six day's hospitalization per year is quite comparable. While the percentage of the nongroup enrollees experiencing more than six day's hospital care per year is higher than the group rate, the difference is not so great with this experienced group as was noted in the total population study.

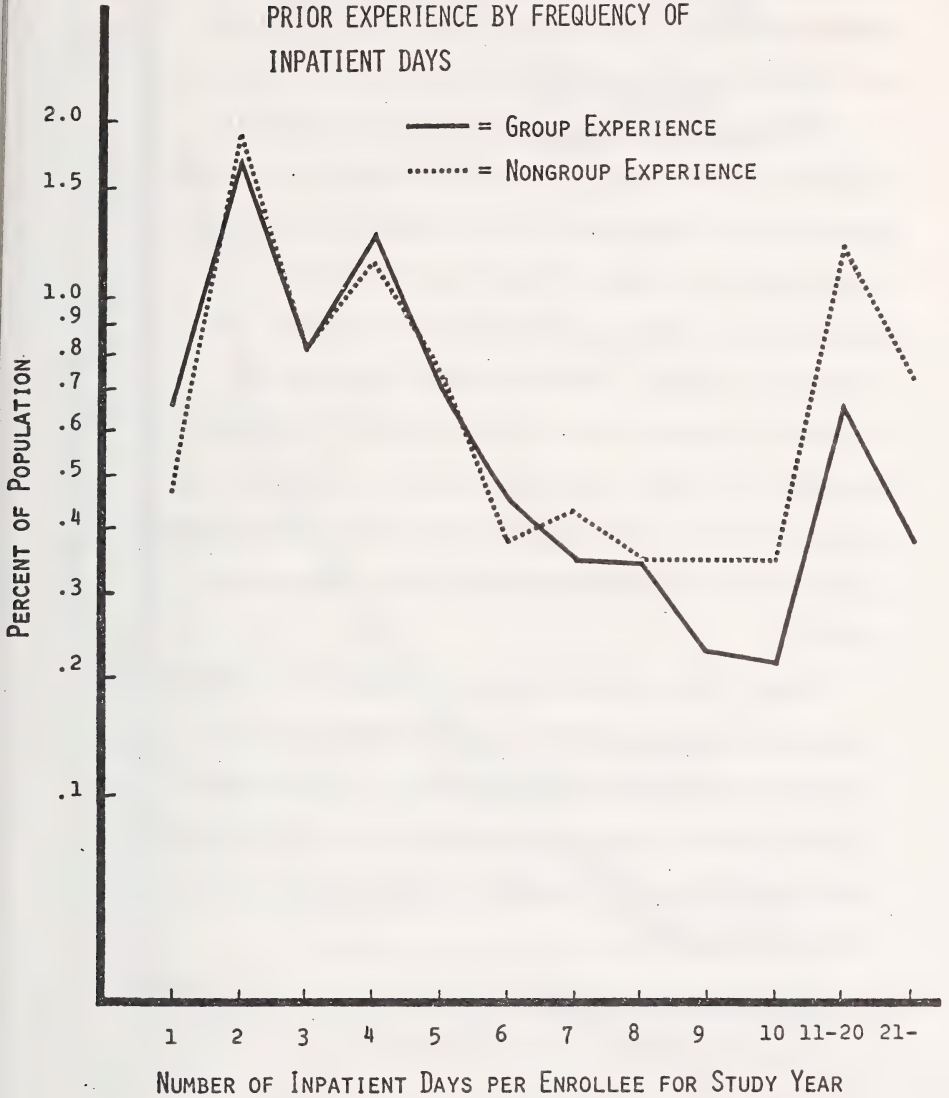
C - Outpatient Costs

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of outpatient costs."

Testing this hypothesis involved the generation of a frequency distribution categorizing group and nongroup enrollees according to the cost of ambulatory care they incurred during the study year. The costing method used to differentiate between cost and charges is subject to the limitations previously mentioned. Group and nongroup enrollees were tallied into any one of 50 cost categories. Each category represented one \$20.00 interval

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY FREQUENCY OF
INPATIENT DAYS



beginning with \$.01 to \$20.00, \$20.01 to \$40.00, etc. and ending with \$980.00. The final "catch-all" category included all enrollees incurring ambulatory costs above this amount.

Subjecting this frequency distribution to the chi-square goodness of fit test yielded a test statistic value of 68.05. The grouping of data describing persons incurring high ambulatory costs resulted in 23 degrees of freedom. Since the test statistic value is higher than the critical 35.127 ($p=.05$), the hypothesis is rejected.⁶ The possibility of generating two frequency distributions which are more dissimilar from their expected values is less than .0005. During the study year, the cost of ambulatory care incurred by group and nongroup enrollees of the GMCHP was significantly different from what can be expected.

Graph V (see next page) overlays the population percentage of group and nongroup enrollees incurring ambulatory costs at the midpoint of \$20.00 intervals described. A greater portion of group enrollees incur annual ambulatory costs of less than \$120 while proportionally more nongroup than group enrollees incur costs higher than this.

6. Ibid., Table A-6, p. 376.

GRAPH V

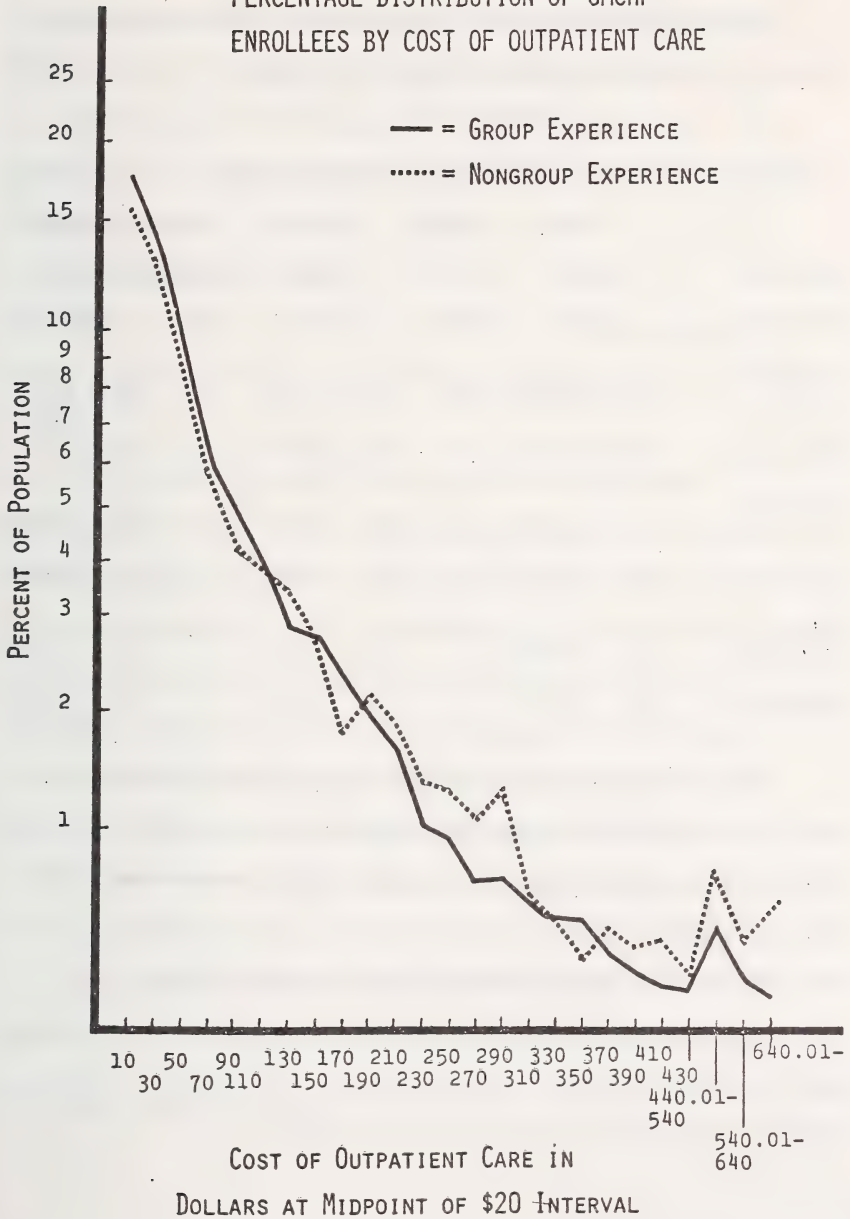
PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY COST OF OUTPATIENT CARE

Table III summarizes the cost of providing ambulatory care to group and nongroup enrollees during the study year.

Table III

Comparison of Group and Nongroup Ambulatory Costs

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Ambulatory Costs	\$644,309.89	73.8	\$229,237.48	26.2	\$873,547.37
(Subgroup)	\$535,404.37	75.3	\$175,404.76	24.7	\$710,809.13
Cost per Enrollee	\$ 63.64		\$ 73.12		\$ 65.88
(Subgroup)	\$ 63.94		\$ 75.48		\$ 66.45
Cost per Encounter	\$ 16.69		\$ 17.81		\$ 16.97
(Subgroup)	\$ 16.69		\$ 17.86		\$ 16.96

While nongroup enrollees account for 23.6 percent of the total population of the GMCHP, they utilize 26.2 percent of the cost of providing ambulatory care to plan members. Table I showed that nongroup enrollees utilize .29 more encounters per year than do group enrollees. This table shows that each encounter utilized by nongroup enrollees is also \$1.12 more expensive than those incurred by group members. This combination of nongroup members incurring more frequent, and more expensive en-

counters than group enrollees results in their annual outpatient health care costs being \$9.48 higher per person per year.

Both group and nongroup enrollees in the subpopulation study incur higher annual ambulatory health care costs than the total population.

2. Subpopulation Study

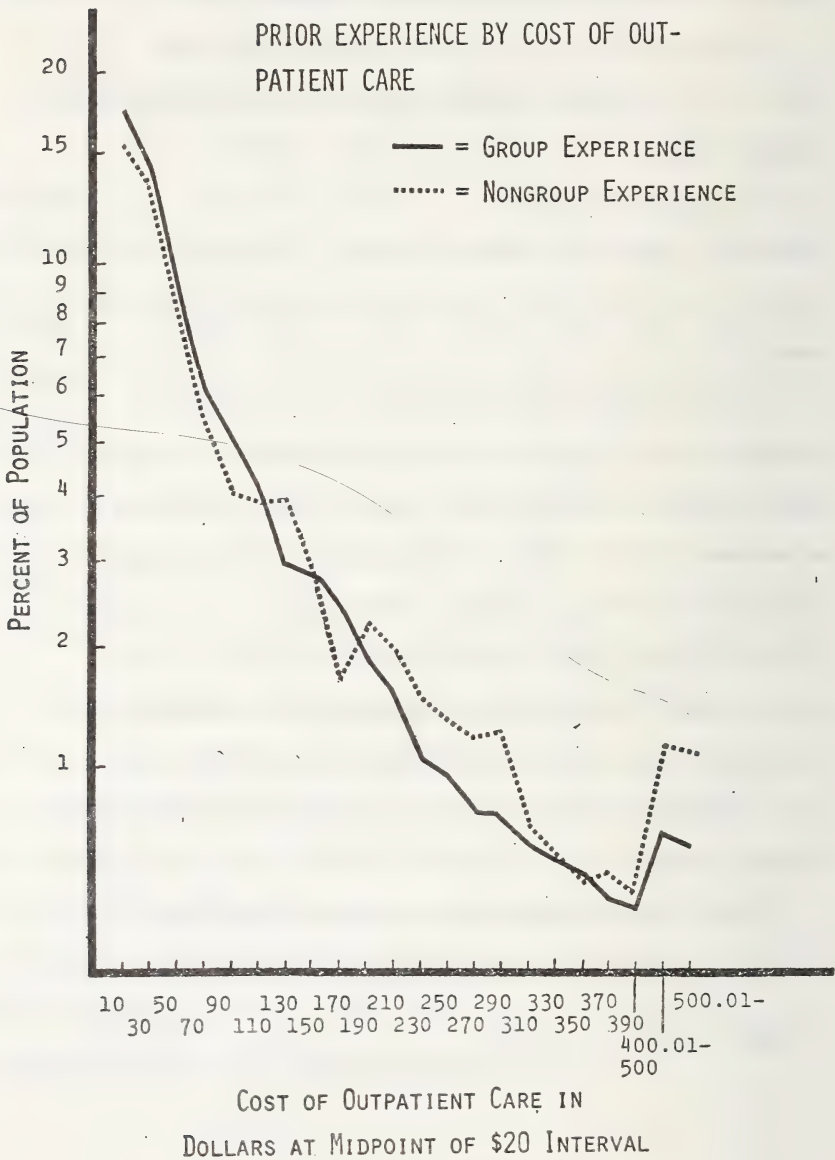
Hypothesis - "Group and nongroup enrollees in the subpopulation have the same set of relative frequencies of outpatient health care costs."

A frequency distribution describing the cost of providing ambulatory health care to this subpopulation of group and nongroup GMCHP enrollees was gathered and analyzed in the same manner as the total population study. Calculation of the chi-square goodness of fit test statistic resulted in a value of 62.65. At 21 degrees of freedom, this is greater than the critical value of 32.671 at a p-value of .05.⁷ The hypothesis is rejected. The probability associated with gathering two frequency distributions more dissimilar from the expected experience than the two observed is less than .0005.

Graph VI (see next page) shows the percent of the group and nongroup population falling into the various \$20.00 intervals

7. Ibid., Table A-6, p. 376.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY COST OF OUT-
PATIENT CARE



of ambulatory health care costs. Variances in the lines describing this subpopulation's ambulatory cost experience are less marked than Graph V depicting the experience of the total plan. The proportions of both group and nongroup enrollees with prior experience in the plan incurring high costs at the tail of the distribution are also higher than the experience of the total plan.

D - Inpatient Costs

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of inpatient costs."

The costs associated with hospitalization include both resources expended for the enrollee by the hospital and by the physician for his services. For purposes of this study, these costs have been approximated. Resources expended by the hospital on plan members are calculated by multiplying an enrollee's length of stay times the \$90.00 per diem rate paid to the hospital. While this does not reflect the true cost to the hospital of providing care to any one patient, it does represent the cost of hospitalization to the plan. The cost of providing physician services is approximated at a percentage of equivalent fee-for-service charges in the same manner as ambulatory costs.

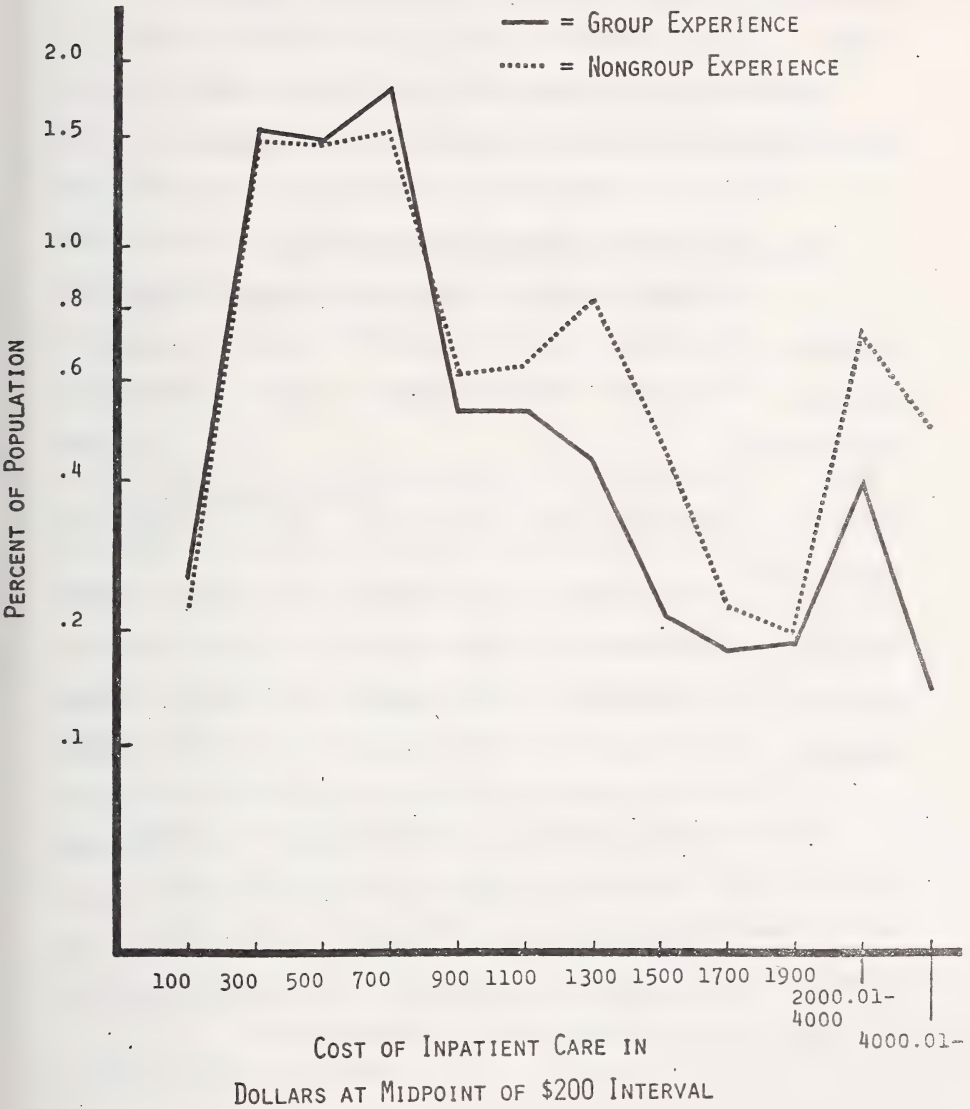
Subject to the above limitations, a frequency distribution was generated categorizing group and nongroup enrollees into 50 \$200.00 intervals describing cost of hospitalization. The last interval categorized patients incurring more than \$10,000.01 in hospitalization costs.

The application of the chi-square goodness of fit test involved the determination of hypothetical expected frequencies for each \$200.00 interval. These were calculated according to the same guidelines previously described. The calculated test statistic associated with the observed distribution was 30.59. Higher cost categories were grouped to achieve greater expected values. This resulted in 10 degrees of freedom. Since the calculated test statistic is higher than the critical 18.307 at 10 degrees of freedom ($p\text{-value}=.05$), the hypothesis is rejected.⁸ Two samplings randomly gathered from the expected frequency of group and nongroup inpatient costs can be expected to vary more than the observed experience less than .005 of the time.

Graph VII (see next page) shows the proportion of the group and nongroup enrollment experiencing inpatient costs at the mid-points of the described \$200.00 intervals. Experience at the tail of the distribution is grouped. The percent of the group and nongroup enrollment incurring hospital costs of less than \$800.00

8. Ibid., Table A-6, p. 376.

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES BY COST OF INPATIENT CARE



during the study year is quite similar. However, proportionally more nongroup enrollees experienced inpatient costs beyond that amount.

Table IV lists some summary data on the inpatient costs incurred during the study year by group and nongroup enrollees.

Table IV

Comparison of Group and Nongroup Inpatient Costs

	<u>Group</u>	<u>Percent</u>	<u>Nongroup</u>	<u>Percent</u>	<u>Total</u>
Population	10,124	76.4	3,135	23.6	10,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Total Inpatient Costs	\$721,607.38	67.3	\$351,149.87	32.7	\$1,072,757.25
(Subgroup)	\$602,201.75	70.0	\$258,062.01	30.0	\$ 860,263.76
Inpatient Cost/ Enrollee	\$ 71.28		\$ 112.01		\$ 80.91
(Subgroup)	\$ 71.92		\$ 111.04		\$ 80.42
Cost/Day	\$ 143.06		\$ 140.80		\$ 142.31
(Subgroup)	\$ 143.18		\$ 142.18		\$ 142.88

The table indicates that while the nongroup enrollees represent 23.6 percent of the total plan, they incur 30.0 percent of the plan's costs associated with inpatient care. This compares with the nongroup's utilization of 33.1 percent of all inpatient days during the study year. The cost per day of inpatient hospitalization is

\$143.06 for group members of the total GMCHP while nongroup members incur average costs of \$140.80 per day.

In the subpopulation study, the cost per hospital day of nongroup members is \$1.38 higher than nongroup enrollees in the total population and more closely approximates the group experience. While the cost per hospital day is higher for these enrollees, their average yearly inpatient cost per enrollee is lower than nongroup members of the total population. The annual inpatient costs per enrollee in the subpopulation of group members with prior experience is higher than the comparable figure for the total plan.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees of the subpopulation have the same set of relative frequencies of inpatient costs."

The frequency distribution describing the hospital and physician costs associated with inpatient care of enrollees in the GMCHP with at least six months experience prior to the study year was gathered and analyzed in the same manner as the total population study. Applying this distribution to the chi-square goodness of fit test yielded a test statistic value of 19.76. At nine degrees of freedom, this exceeds the critical value of 16.919 at a p-value of .05.⁹ The hypothesis is rejected. The

9. Ibid., Table A-6, p. 376.

probability associated with gathering two samples from the expected distribution of this subpopulation's hospital costs which vary more than observations taken during the study year is less than .025.

The percent of group and nongroup enrollees with prior experience in the plan falling into the various \$200.00 intervals describing inpatient costs are depicted on Graph VIII (see next page.) The plotted group and nongroup experience with annual inpatient costs less than the \$900.00 interval for this subpopulation is quite similar to Graph VII depicting the total population. However, the frequency of enrollees of the two units falling into inpatient costs intervals beyond this amount more closely approximate each other in this subpopulation study.

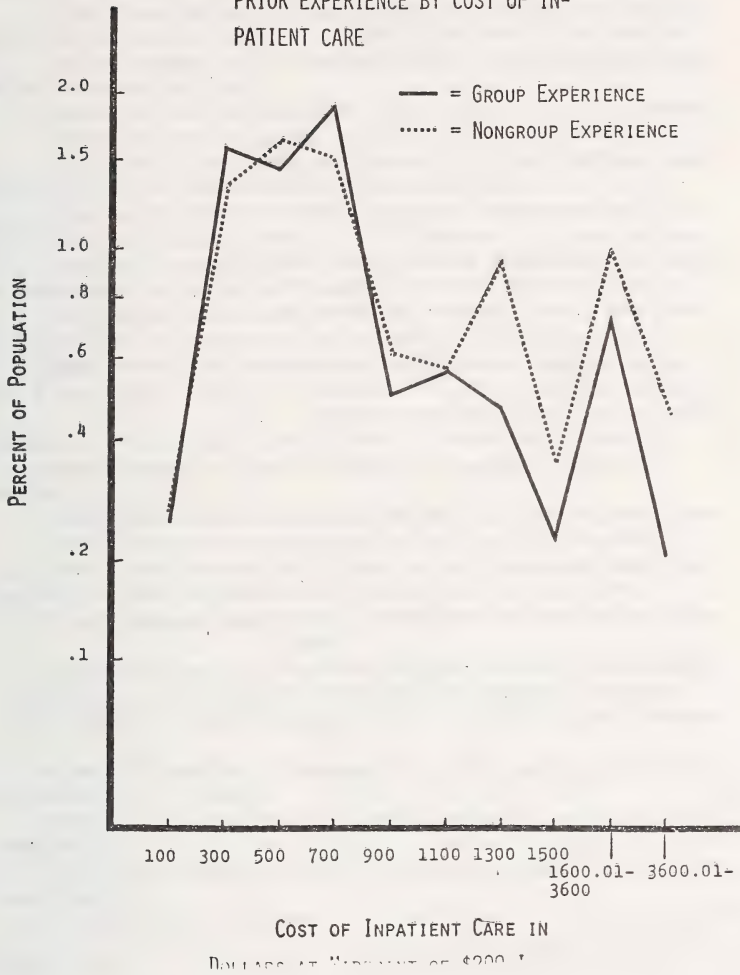
E - Total Health Care Costs

1. Total Population Study

Hypothesis - "Group and nongroup enrollees of the GMCHP have the same set of relative frequencies of total health care costs."

The testing of this hypothesis involved the generation of a frequency distribution categorizing group and nongroup enrollees into intervals describing total inpatient and outpatient costs incurred by those enrollees during the study year. Not included in the data generated are the costs associated with the accounting administration of the plan and costs associated with out-of-area

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY COST OF IN-
PATIENT CARE



emergency and referral service. Blue Cross and Surgical Blue Shield of Wisconsin are at risk for these plan components. This partner in the GMCHP charges \$1.00 per enrollee per month to cover accounting, administration, and marketing of the plan. During the study year, they received \$.41 per person per month to cover all out-of-area costs. Realized out-of-area costs for plan members were \$.31 during the study year. Since it is difficult to determine what portion of these amounts are associated with providing health care to group and nongroup enrollees since Blue Cross receives the same amount per enrollee month, it is felt that omission of this from the cost data has a negligible effect on the findings of this section.

As in the inpatient cost study, group and nongroup enrollees were categorized into \$200.00 cost intervals describing health care costs incurred with the plan. The interval limits were the same as the hospital cost study. Subjecting the generated frequency distribution to the chi-square goodness of fit test yielded a test statistic value of 46.36. This is greater than the critical value of 19.675 ($p\text{-value} = .05$) at 11 degrees of freedom.¹⁰ Two randomly gathered samplings taken from the expected distribution of group and nongroup enrollees incurring health care costs

10. Ibid., Table A-6, p. 376.

during the study year can be expected to vary more than the observed distribution less than .0005 of the time. The hypothesis is therefore rejected.

Graph IX (see next page) depicts the percent of the group and nongroup population incurring annual health care costs at the midpoint of the described \$200.00 intervals. As can be seen on the graph, the group and nongroup experience does not vary markedly until health care costs exceed \$1,200.00 per person. The proportion of nongroup enrollees incurring costs beyond this amount is notably higher than a similar proportion of group enrollees.

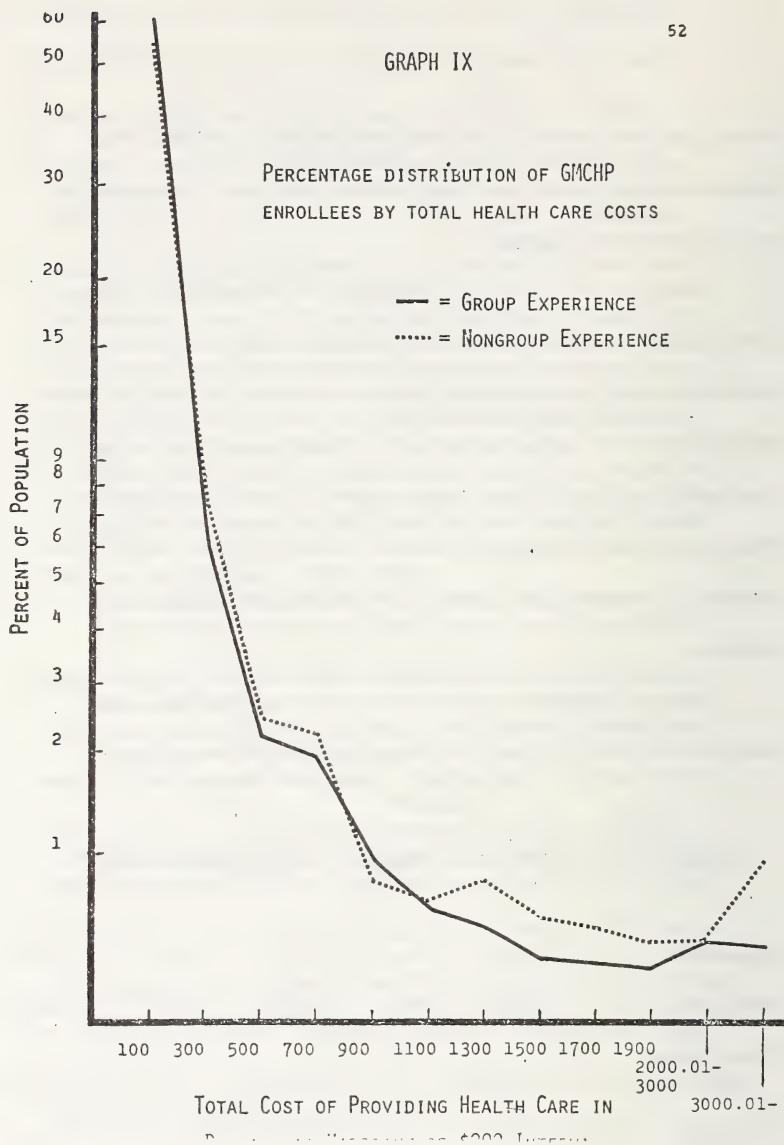
Table V lists summary information regarding the total health care costs of group and nongroup GMCHP enrollees.

Table V

Comparison of Group and Nongroup Total Health Care Costs

Population	10,124	76.4	3,135	23.6	13,259
(Subgroup)	8,373	78.3	2,324	21.7	10,697
Total Health Care Costs	\$1,366,058.44	70.1	\$581,522.74	29.9	\$1,947,581.18
(Subgroup)	\$1,137,667.01	72.4	\$434,458.08	27.6	\$1,572,125.09
Cost/En- rollee/ Month	\$ 11.24		\$ 15.46		\$ 12.24
(Subgroup)	\$ 11.32		\$ 15.58		\$ 12.25

GRAPH IX



As the table shows, nongroup enrollees in the total plan represent 23.6 percent of its population while accruing 29.9 percent of the inpatient and outpatient health care costs expended. The mean cost of providing health care to a nongroup enrollee per month is \$4.22 higher than for group enrollees. Because of the percentage mix of group to nongroup enrollees in the total GMCHP, group enrollees pay \$1.00 per month per person to underwrite the health care costs of the nongroup enrollees. Considering administrative and out-of-area costs (adding \$1.41 to group, nongroup, and total health care costs per enrollee per month,) nongroup enrollees utilize 25.0 percent more health care resources than do group enrollees.

Group and nongroup enrollees with at least six month's experience in the plan prior to the study year both incur monthly health care costs which are higher than the total population. However, due to their percentage mix of group to nongroup enrollees, this subgroup's mean monthly health care cost is only \$.01 higher than that of the total population.

2. Subpopulation Study

Hypothesis - "Group and nongroup enrollees of the subpopulation have the same set of relative frequencies of total health care costs."

This frequency distribution categorizing group and non-group enrollees with experience in the plan according to their total health care costs was gathered and analyzed in the same manner as the total population study. Application of the chi-square goodness of fit test to the distribution generated yielded a test statistic value of 34.25. Allowing 10 degrees of freedom, this value is greater than the critical 18.307 at a p-value of .05.¹¹ The hypothesis is rejected. The probability associated with gathering two samplings from the hypothetical expected distribution more varied than the observed group and nongroup health care costs of this subpopulation is less than .0005.

A percentage of population distribution categorizing this subpopulation of group and nongroup enrollees at the midpoint of the \$200.00 interval describing their total health care costs for the study year is depicted with Graph X (see next page.) As in Graph IX, the percentage of nongroup enrollees experiencing health care costs beyond \$1,200 is notably higher than the group experience.

11. Ibid., Table A-6, p. 376.

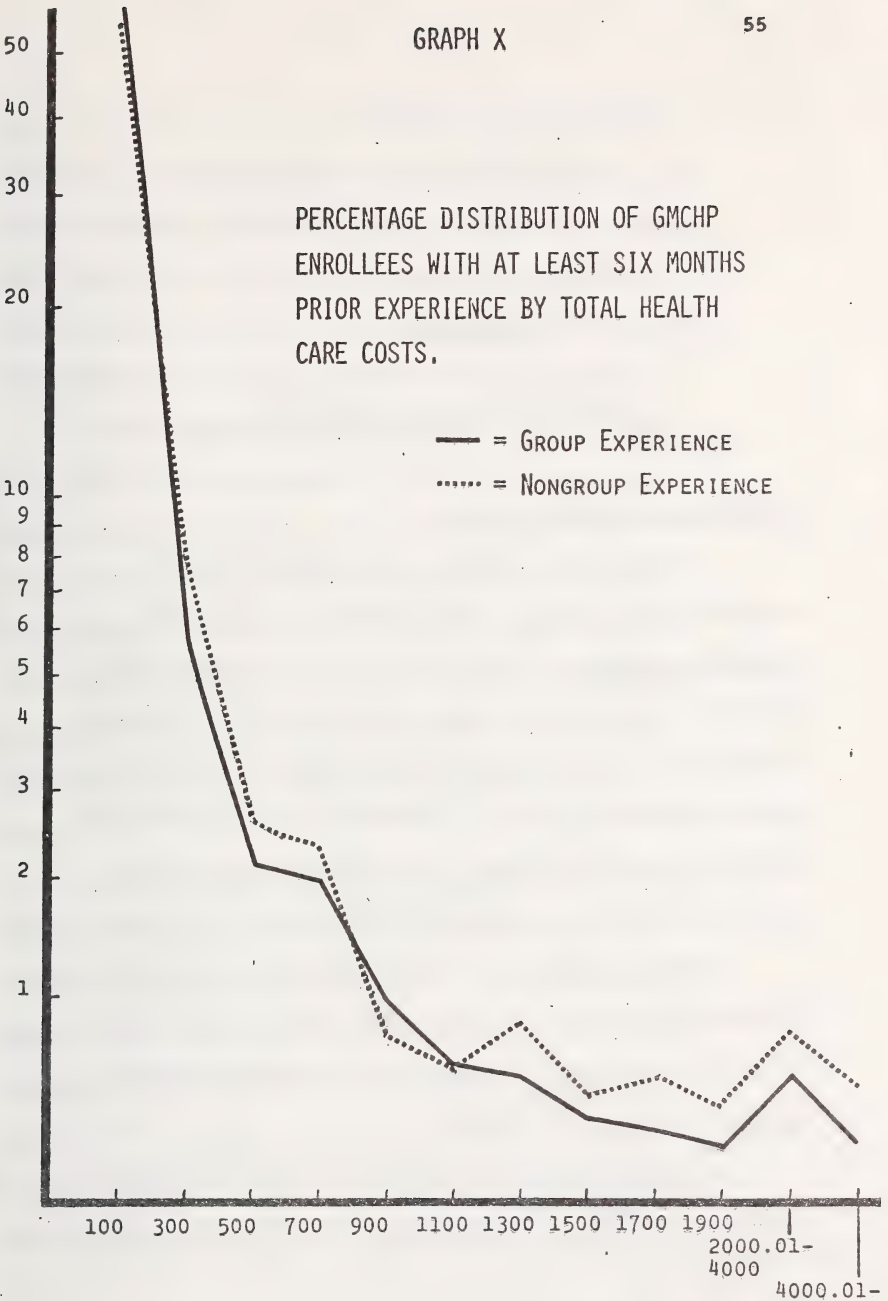
GRAPH X

55

PERCENTAGE DISTRIBUTION OF GMCHP
ENROLLEES WITH AT LEAST SIX MONTHS
PRIOR EXPERIENCE BY TOTAL HEALTH
CARE COSTS.

PERCENT OF POPULATION

— = GROUP EXPERIENCE
..... = NONGROUP EXPERIENCE



TOTAL COST OF PROVIDING HEALTH CARE IN
DOLLARS AT MIDPOINT OF \$200 INTERVAL

CHAPTER IV

SUMMARY OF MAJOR FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

A - Summary of Major Findings

1. Based on the encounters experienced by the total population of the GMCHP, nongroup enrollees utilize more outpatient encounters than do group members of the plan. The greatest variances between group and nongroup use of outpatient services occur with those enrollees utilizing eight or more outpatient encounters per year. The average rate of encounter per enrollee during the study year was 3.882 while nongroup enrollees experienced an average of 4.106 encounters per year.

2. The utilization of ambulatory health services of nongroup enrollees with at least six months experience in the plan prior to the beginning of the study year does not vary significantly from what can be expected.

3. Nongroup enrollees utilize more inpatient hospital days than group enrollees. The greatest variances between group and

nongroup experience seems to occur with those enrollees experiencing more than nine days of hospitalization per year. A greater proportion of the group population utilizes less than six days hospitalization per year while a greater proportion of the nongroup population utilizes more. Nongroup enrollees experience nearly 300 hospital days per 1,000 more than group members.

4. Nongroup enrollees of the GMCHP with at least six months experience in the plan prior to the study year utilize inpatient care consistent with what can be expected. This nongroup unit, as a subpopulation of the nongroup unit described in the total population study, utilizes nearly 15 hospital days per 1,000 population less than the total nongroup unit. Comparably, the subpopulation group unit utilizes over four more days per 1,000 population than the group unit of the total population study.

5. The frequency of group and nongroup enrollees of the total GMCHP falling into \$20.00 intervals describing annual outpatient costs is significantly different. The average nongroup enrollee utilizes \$9.48 worth more ambulatory health care resources per year than does a group member. The mean cost per encounter of nongroup enrollees is \$17.81 compared to \$16.69 for group members. On the average, nongroup enrollees utilize more expensive encounters more often than do group enrollees.

6. As in the total population, nongroup enrollees in the subpopulation incur higher ambulatory health care costs than do group members with at least six months prior experience in the plan.

7. The cost of providing inpatient care to a nongroup enrollee in the GMCHP is higher than for a group member. However, the cost per hospital day is \$2.26 lower for these nongroup enrollees. On the average, group enrollees utilize less expensive inpatient care more frequently than group enrollees.

8. Nongroup enrollees of the subpopulation expend more resources for inpatient care than do group enrollees with prior experience in the plan. However, the plan spends fewer dollars per year for inpatient care on the average nongroup enrollee with prior experience than for those of the total plan. Nongroup enrollees with prior experience, while utilizing fewer hospital days than those of the total population, use more expensive inpatient care as measured by the cost per day of hospitalization. In contrast, the more experienced group enrollees utilize slightly more inpatient care than group members of the total plan.

9. Nongroup enrollees utilize 25.0 percent more health care resources measured in dollars than do group members. Considering the ratio of group to nongroup enrollees in the GMCHP, each single group enrollee pays \$1.00 per month to underwrite the health care costs of the nongroup members.

10. The total health care costs of both group and nongroup enrollees with six months prior experience is higher than respective units of the total health care plan. Group members of this subpopulation pay \$.93 per person per month to underwrite the health care costs of nongroup members of the subpopulation.

B - Conclusions

The above described findings lead the reader to several conclusions regarding health care utilization by nongroup members of the GMCHP as well as the validity of certain measures thereof.

1. Members of the GMCHP who enter the plan irrespective of their place of employment or pre-existing conditions during an open enrollment period utilize more health care resources than group enrollees in terms of both utilization of services and cost of providing those services.

2. The health care utilization behavior of nongroup enrollees with at least six months prior experience in the plan is different from that of all nongroup enrollees. These experienced nongroup members use more outpatient care and less inpatient care when compared to all nongroup enrollees. The health care behavior of group enrollees with experience is not affected in this manner.

3. The value of utilization statistics (i. e. outpatient encounters and inpatient days) when comparing even two units

within the same health plan may not reflect the true health care resources expended for that unit.

The importance of the small difference between the mean encounter rate of group and nongroup enrollees is magnified with the knowledge that the average nongroup encounter costs \$1.12 more. The difference between group and nongroup inpatient utilization is somewhat lessened by the fact that the average cost per nongroup incurred hospital day is \$2.26 less than for the group.

4. According to the frequency distributions generated, the bulk of the differences between group and nongroup utilization and cost of providing care occurs with a small percentage of nongroup enrollees who tend towards high utilization.

C - Recommendations

This study was undertaken to investigate the effects of an open enrollment on the utilization and costs of providing care in a prepaid group practice. Further, it was hoped that this study would demonstrate that these effects are not so dramatic as to prohibit an operational or developing prepaid group practice from including this segment of the health consumer population within its eligible population.

Utilizing the data files of the Marshfield Clinic, all enrollees of the GMCHP for a given year were categorized according

to group and nongroup status and displayed in frequency distributions describing outpatient and inpatient utilization, cost of outpatient care, cost of inpatient care, and total health care costs experienced. A second study similar in structure to the first was undertaken displaying only those group and nongroup enrollees with at least six months experience in the plan prior to the study year.

The study indicated that nongroup enrollees utilize 25 percent more health care resources measured in dollars than do group members. This difference is less in the group and nongroup subpopulation with at least six months prior experience in the plan.

Since legislators and consumers are encouraging HMOs to open their enrollments to the total population, it is hoped that this document will serve to describe one plan's experience with utilization, cost of providing care, and risk implications of such a policy.

In light of the findings of this study, the author recommends that the GMCHP continue its open enrollment and community rating policies. The degree to which group enrollees underwrite the health care costs of nongroup members is not prohibitive and tends to decrease with experience in the plan.

Certain characteristics unique to both the Greater Marshfield Community Health Plan and the community which it serves make generalization from the open enrollment experience described in this paper to other health plans difficult. However, insofar as current literature is void of any description of an HMO's experience with a community rated open enrollment, this pilot study may be taken as a base line for the experience of others.

If the Health Maintenance Organization is ever to conclusively demonstrate its viability as an alternative health care delivery system, it must do so by serving a true cross section of the population. The findings of this study demonstrate that providing all consumers--irrespective of employment or pre-existing conditions--with prepaid health care is not excessively prohibitive to the financial success of the plan. Therefore, the author would finally suggest that practicing and developing HMOs seriously consider establishing a policy of open enrollment.

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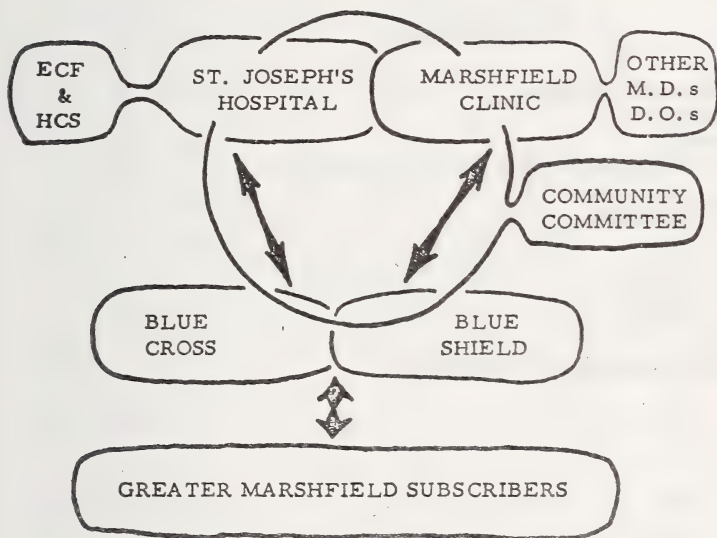
APPENDIX A



APPENDIX B

GREATER MARSHFIELD COMMUNITY HEALTH PLAN
COMPONENT LINKAGES

1. Marshfield Clinic: Provides medical services in and out of the hospital and makes separate contractual arrangements with affiliated physicians.
2. St. Joseph's Hospital: Provides inpatient services and makes arrangements for nursing home and home health care.
3. Blue Cross - Blue Shield: Perform marketing, enrollment, actuarial, claims and out of area services and administration.
4. Community Committee: Advice and guidance to the plan partners.



APPENDIX C
GMCHP BENEFITS

Complete coverage for:

Medical Care (Ambulatory and Inpatient)
Hospital, ECF, Home Care
Outpatient
Emergency Out of Area Service
Referral Care

Inpatient Care - 365 days (does not include psychiatric)

ECF 2 for 1 Home Care 5 for 1

Mental Health Care - Up to 70 days - inpatient
(70 more after 90)

Up to 10 mental health visits
(10 more after 90)

No physical exam required
No deductibles
No co-payments
No "pre-existing" exclusions (except maternity)

DOES NOT INCLUDE:

Outpatient drugs
Prosthetic devices
Cosmetic surgery
Eyeglasses
Dental care (other than oral surgery)

APPENDIX D

SAMPLE OF CHI-SQUARE COMPUTATION:

OUTPATIENT ENCOUNTERS--TOTAL POPULATION

Number of Encounters	People		Expected Frequency*		(O-E) ² /E	
	Group	Nongroup	Group	Nongroup	Group	Nongroup
0	2638	854	2667.9	824.1	.34	1.08
1	1606	451	1571.5	485.5	.76	2.45
2	1263	360	1240.0	383.0	.43	1.38
3	938	305	949.7	293.3	.14	.47
4	755	234	755.6	233.4	.00	.00
5	594	167	581.4	179.6	.27	.88
6	425	139	430.9	133.1	.08	.26
7	355	106	352.2	108.8	.02	.07
8	266	98	278.1	85.9	.53	1.70
9	211	76	219.3	67.7	.31	.99
10	170	54	171.9	52.1	.02	.07
11	180	36	165.0	51.0	1.36	4.41
12	111	36	112.3	34.7	.02	.05
13	114	33	112.3	34.7	.03	.08
14	85	30	87.9	27.1	.10	.31
15	66	21	66.5	20.5	.00	.01
16	55	24	60.4	19.6	.48	1.49

Number of Encounters	People		Expected Frequency*		(O-E) ² /E	
	Group	Nongroup	Group	Nongroup	Group	Nongroup
17	56	12	52.0	16.0	.31	1.00
18	37	15	39.7	12.3	.18	.59
19	29	16	34.4	10.6	.85	2.75
20	23	8	23.7	7.3	.02	.07
21	22	5	20.6	6.4	.10	.31
22-26	62	20	62.6	19.4	.01	.02
27-31	26	9	26.7	8.3	.02	.06
32-41	15	7	16.8	5.2	.19	.62
42-	19	19	29.0	9.0	3.45	11.11
Total Frequency	10,124	3,135			$\chi^2=42.25$	
Relative Frequency	.764	.236	.764	.236		

* Expected frequencies are obtained by multiplying the percent of population that is group and nongroup by the total number of observations within a class of encounters.

APPENDIX E

SAMPLE OF HYPOTHESIS TESTING:
OUTPATIENT ENCOUNTERS--TOTAL POPULATION

$$X^2 \leq \frac{(O-E)^2}{E} = 42.25$$

Degrees of freedom = (r-1) (c-1) = 25

Reject H_0 where $X^2 > 37.652$

At 25 degrees of freedom, the P-value of $X^2=42.25$ is .018. Since the level of significance for the P-value was set at .05 (i. e. if P-value is equal to or less than .05, reject the null hypothesis), the hypothesis is rejected.

APPENDIX F
SUMMARY OF CHI-SQUARE RESULTS

Factor	X^2	Degrees of Freedom*	P-value	Accept- Reject H_0 **
Outpatient Encounters	42.25	24	$< .025$	Reject
(Subpopulation)	30.95	22	$> .05$	Accept
Inpatient Days	27.34	12	$< .01$	Reject
(Subpopulation)	17.25	11	$> .10$	Accept
Outpatient Costs	68.05	23	$< .0005$	Reject
(Subpopulation)	62.65	21	$< .0005$	Reject
Hospital Costs	30.59	10	$< .005$	Reject
(Subpopulation)	19.76	9	$< .025$	Reject
Total Costs	46.36	11	$< .0005$	Reject
(Subpopulation)	34.25	10	$< .0005$	Reject

* Degrees of freedom vary due to grouping of data at the tails of a distribution.

** Hypothesis is rejected where P-value of X^2 or = to .05.

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Senator NELSON. Thank you very much the hearing is now adjourned. [Whereupon, at 1:26 p.m., the subcommittee adjourned, subject to the call of the Chair.]

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS, 1975

MONDAY, JANUARY 19, 1976

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:13 a.m., in room 4232, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senator Kennedy.

Staff present: Philip Caper, M.D., professional staff member, and Jay B. Cutler, minority counsel.

Senator KENNEDY. The subcommittee will come to order.

I am pleased to open this final day of hearings on the health maintenance organization amendments of 1975.

We have had 2 days of hearings concerning these amendments so far.

Following the conclusion of today's hearing, I would like to move this legislation as quickly as is consistent with the other business of the Health Subcommittee.

I want to welcome our witnesses today. Our first witness this morning is no stranger to this committee, Mr. Bert Seidman, who is the director of the social security department of the AFL-CIO. He has been a good friend and valued counselor of this committee, and we are always glad to have him here.

STATEMENT OF BERT SEIDMAN, DIRECTOR, SOCIAL SECURITY DEPARTMENT, AFL-CIO, ACCOMPANIED BY ROBERT M. McGLOTTEN, LEGISLATIVE REPRESENTATIVE, AND RICHARD E. SHOEMAKER, ASSISTANT DIRECTOR, DEPARTMENT OF SOCIAL SECURITY

Mr. SEIDMAN. Thank you, Mr. Chairman. My name is Bert Seidman. I am director of the department of social security of the AFL-CIO.

With me to my left is Robert McGlotten, member of the legislative department of the AFL-CIO. And to my right is Richard Shoemaker, assistant director of the department of social security of the AFL-CIO and our expert in the health field.

Mr. Chairman, I am of course testifying on behalf of the AFL-CIO. But I think it is worthwhile stating that I have had long experience in the group health movement. I've been a member of the Group Health Association here in Washington, D.C., for 28 years. For the

past 6 years I've been a member of the board of trustees of that organization and am now its first vice-president.

So I speak with some knowledge and experience on the problems and potentialities of prepaid group practice plans in particular and HMO's in general.

I will try to summarize my statement, Mr. Chairman, but I do ask that the complete text of the statement be inserted in the record of the hearing.

Senator KENNEDY. It will be so included at the conclusion of your testimony.

Mr. SEIDMAN. Mr. Chairman, on behalf of the AFL-CIO I wish to thank you for the opportunity to present our views with respect to H.R. 9019, the House-passed bill, and S. 1926, introduced with bipartisan support by Senators Schweiker, Javits and Mondale. We wish to commend you and the members of your subcommittee for considering the health maintenance organization amendments of 1975 so promptly after the House has acted.

S. 1926 is designed to amend the Health Maintenance Organization Act of 1973 to make it more workable and more practical. In fact, we would go so far as to say that unless Congress passes S. 1926—with the addition of two improvements which we are going to suggest—the great potential and opportunity that the HMO Act holds for improving the delivery of quality health services and of containing the escalation in medical care costs will not be achieved.

S. 1926 includes a substantial number of amendments to the HMO Act, some of which are technical in nature. Witnesses from the "Consensus Group" have testified in detail with respect to the need for these amendments which, with one exception, we generally support in their present form. Therefore, in the interest of conserving time and avoiding needless repetition, we will restrict our comments mainly to what we regard as the most important issues. These are: (1) the need for an additional amendment to clarify the intent of the so-called "dual choice" provision of the act; (2) a modification in section 7 of S. 1926, which would amend section 1302(4)(c)(i) of the act requiring the members of a medical group of an HMO to have as their principal professional activity the provision of health care for the prepaid enrolled members of the HMO; (3) reducing the mandated basic package of benefits under the present law; and (4) elimination of the open enrollment provisions of the present act.

First, let me deal with section 1310 of the HMO act, the so-called "dual choice" requirements of the law.

Let me say at the outset that amendment of this provision should not have been necessary. We do not believe that Congress had any intent, when the HMO Act was enacted, of utilizing this legislation to curtail, weaken, or bypass the long-recognized right of unions to bargain collectively on behalf of their members with respect to health and welfare benefits.

We're glad to say this apparently is no longer a controversial subject, and we hope the subcommittee will accept the action that the House has taken.

Since our testimony before the House subcommittee last July, the administration has modified its position and the final regulations issued last month are quite satisfactory in this regard. However, because of

the potential harm that could result if, at some future date, the regulations were changed, we urge that the amendment to section 1310 now contained in H.R. 9019 be incorporated in any bill reported out of the Labor and Public Welfare Committee. It is essential that the issue be cleared up in the law and not just in the regulations.

When Dr. Cooper, Assistant Secretary for HEW, testified before your subcommittee, he recommended that section 1310 should define "employer" by reference to the National Labor Relations Act and the Labor Management Relations Act rather than the Fair Labor Standards Act, as in present law.

The AFL-CIO is opposed to this proposal. The definition of "employer" in the NLRA is too restrictive. For example, farm workers, Government employees, and other employees in industries that the National Labor Relations Board elected not to cover, would be denied the benefits of section 1310. Therefore, we favor continuing the definition of "employer" in the HMO Act as it is in the Fair Labor Standards Act.

Now I turn to the requirements for an HMO medical group, which is in section 7.

This section of S. 1926 eliminates the provision of the present HMO Act that would require a medical group to devote its professional time principally on behalf of the enrollees of the HMO. HEW has interpreted this requirement to mean that at least 51 percent of the time of the doctors in the group must be devoted to the HMO members. Certainly, this is the minimum requirement that could have been set in accordance with the law. We see no reason for it to be eliminated. It is on this point that we differ from the consensus group which testified before your subcommittee on December 12, 1975.

The issue here is whether or not the medical group is committed to move in the direction of prepayment and capitation as the principal means of reimbursement. Without a majority of prepaid patients, all the advantages of budgeting and planning to meet the medical needs of an enrolled population virtually disappear. Where most patients go to a medical group for their care on a haphazard basis and pay for each service separately, the need for hospital beds as well as the number and kinds of physicians and other medical personnel needed cannot be determined with any accuracy. The ability to plan effectively and economically must rest on solid assumptions as to the medical care needs of a known population.

There are other dangers as well. If capitation is to be just another method of reimbursement for the medical group, income to the medical group may be maximized by retaining the more affluent patients under fee-for-service reimbursements while accepting the less affluent on a guaranteed income, for example, under capitation. The fee-for-service patients become the preferred patients because they bring in additional income and the capitation patients do not receive equivalent consideration. This is not just theory. This has happened with one major prepaid group practice plan which has had to require its doctors, who had derived a large part of their income from fee-for-service, to devote their time mainly to the HMO members with payment by capitation.

With less than a full commitment to prepayment, an HMO may contract with a State for medicaid eligibles and retain its wealthier pa-

tients on a fee-for-service basis. This would mean a two-class delivery system. We are strongly opposed to giving medical groups an economic incentive to maintain the two-class system. Therefore, we favor retaining the standard in the present law that a medical group serving an HMO should devote most of its time to providing health services for its enrolled members. However, in order to facilitate the conversion of fee-for-service multi-specialty groups to prepayment, we would favor phasing in this requirement over a period of 5 years just as the community-rating requirement in the present law would be phased in over 5 years by section 6 of S. 1926.

We recognize that in some few instances, a medical group may never, at least until such time as there is a comprehensive national health insurance program, be able to meet this standard. For example, a multi-specialty group practice may be located in a rural area with few employee-employer health benefit plans. In such case, it would be difficult for the medical group to provide most of its medical services to its prepaid enrolled members. Another example would be where one of the prestigious multi-specialty groups, such as the Mayo or Geisinger clinics, had such a large volume of referral patients that it could not meet the standard without giving up its referral patients—obviously an unreasonable requirement.

The answer to this problem is, in our opinion, not to weaken the standard, but to grant the Secretary of HEW authority to make exceptions for good and sufficient cause.

We hope, therefore, that the subcommittee will retain this provision of the HMO Act but phase it in over a 5-year period and provide for exemptions by the Secretary upon a showing that the goal cannot reasonably be attained.

Senator KENNEDY. Mr. Seidman, compared to the group, the alliance, or the association that is proposing these various amendments, this is one area where you differ with them; is that correct?

Mr. SEIDMAN. That is correct.

Senator KENNEDY. Do you believe it is important that we maintain that which was to make it the principal activity which has been defined under the regulations to be 51 percent of the activities which would be without the HMO?

Mr. SEIDMAN. With two elements of flexibility, Mr. Chairman.

Senator KENNEDY. Now, the point that has been made during the course of these hearings is that by striking that particular provision we may be encouraging other groups to come into this activity that otherwise might not be willing to do so because of the restriction saying that their primary function is going to be in the HMO. And if they are not sufficiently prepared to insist that 51 percent of the activity be directed toward the HMO, then there should be discretion within the Secretary to waive that particular provision. Do I understand your case correctly?

Mr. SEIDMAN. Yes, and particularly for certain types of clinics; for example, the Mayo or the Geisinger Clinic, which have the large volume of referral patients and where they simply could not be expected to meet the standards without giving up their referral patients.

We think that in the ordinary type of HMO, fee-for-service, that this transition could take place over a period of 5 years.

Senator KENNEDY. Why are you willing to grant the discretion of waiver to the Secretary in this area and yet you are reluctant to grant the discretion of waiver to the Secretary in the areas of open enrollment?

Mr. SEIDMAN. Because in the case of the open enrollment we see the possibility that small HMO's—here we are not talking about organizations which are already on their feet, which have been providing services for a long time, and we are really not talking about creating new fee-for-service HMO's. But in the case of the prepaid group practice plans with which we are principally concerned, particularly those that are getting underway, we think that to require open enrollment for individuals, I stress that point because of course there will be open enrollment as far as groups are concerned, but for individuals that this would put them at a very, very serious financial risk and I think would make it very, very difficult for them to get underway.

Now, you can say, well, the Secretary would have the discretion. But the problem is that the Secretary, as you know, Mr. Chairman, has not shown sufficient interest in this program to assure that these decisions will be made very, very quickly. In the meantime, new HMO's could die on the vine.

Senator KENNEDY. Why not use the same logic in existing programs to have the open enrollment provisions? Why not do the same thing with regard to open enrollment in areas where they already have some kind of existing prepaid program and are already in existence, like the Harvard plan?

Mr. SEIDMAN. Well, in the first place, I think that the Harvard plan—I do not have detailed familiarity with the Harvard plan—but even the Harvard plan or the New Haven plan, some of these plans that have recently gotten underway, I think they would be in serious difficulty. I do not know whether Kaiser would. I think at Group Health Association we might have a very serious problem. The experience I think in the case of the New Evanston plan is very illustrative in this respect. What apparently is happening in Evanston where they tried to have open enrollment when they first got underway was that insurance companies were referring their sickest people to the Evanston plan.

Mr. Chairman, we say that we would never come in with any such recommendation if the health security bill were enacted. We would recommend that if such a requirement is going to be placed on HMO's, the very same requirement should be placed on all other plans. But we ask that the HMO's not be asked to carry this kind of a burden of trying to meet the competition of well-established, well-financed, types of health care which do not have to meet these requirements. And moreover, prepaid group practice plans have not been able to do this. Instead, they have had open enrollment for the great majority of their patients. Why? Because they come from groups and with groups you can achieve a certain actuarial balance. But where they take individuals, they do have restrictions with respect to preexisting conditions and so on, and they have to do so. They have had to do so very reluctantly.

It is not anything they like to do. But if they did not do so, then they would be in a very, very difficult competitive position.

Senator KENNEDY. You do not think that the 51-percent rule will discourage many fee-for-service groups from seeking to become HMO's?

Mr. SEIDMAN. I do not think so. I think that the 51-percent rule would still permit them to maintain a very considerable fee-for-service practice and if this involves expansion, then it would mean that they would have the prepaid group practice, and they would still maintain their fee-for-service operation.

Mr. Shoemaker wanted to add a comment.

Mr. SHOEMAKER. I think you will find that most of the multispecialty groups already have varying degrees of enrollments on a capitation basis, 5 or 10 percent, for example. The important point is that if there is no commitment on the part of the medical staff for prepayment, I cannot see any sense in giving development grant of \$1 million to a group who is going to handle small minority of prepayment patients.

Now, in certain instances, Marshfield Clinic is one, where only 40 percent can afford the plan, obviously they have to serve the rest of the population on a fee-for-service. That would be the type of exemption the Secretary should make. If they cannot make it, they cannot make it. If there is no commitment toward prepayment, I do not see why we are giving them the million dollars, frankly.

Senator KENNEDY. What about a phased-in kind of period? How about giving them time so they could at least try and move in that direction?

Mr. SEIDMAN. Are you talking about the 51-percent rule?

Senator KENNEDY. Yes.

Mr. SEIDMAN. We are suggesting that there should be a 5-year period.

Senator KENNEDY. That is the expiration of the bill.

Mr. SEIDMAN. I have not thought of that coincidence. We thought of the 5-year period as being a reasonable period for a phase-in. We were not thinking about it in terms of the expiration date of the bill. If for that reason some other period seems to be better, we would not have any strong objection.

Senator KENNEDY. We would like to work with you on it.

Mr. SEIDMAN. Turning now to the question of the benefit package—

Senator KENNEDY. We will include that. I do not think we have much of a problem in the benefit package. You have basically the same position as the various groups.

Mr. SEIDMAN. As the consensus group on that point, yes.

Senator KENNEDY. If there is something in particular you want to comment on, fine, but what I would be interested in is from your own study of what you think are actually going to be the savings by altering the benefit package. I would be very interested in this. We have been attempting to mold and shape a benefit package. I am interested in whether you think the trade-offs that have been put forward by the various proposals are really going to make very much of a difference. Our staff people do not think there is going to be very much in terms of savings, that the significance of it is not very dramatic. But I would be interested in what comments you have to make.

Mr. SEIDMAN. The issue is not simply to savings, because admittedly the figures are soft as to what the savings would be. I think they would vary a great deal from one plan to another. The reason I say this is

that a large plan, if it is required to provide a certain service, is in a position to simply take on the staff, to provide the service. It may already conceivably have the equipment or most of the equipment. In that case, perhaps the saving will not be very great. A small plan is entirely in a different situation. It is required to provide the service. If it cannot economically provide the service itself, than it has to go out and purchase the service in the community. At that point, it becomes a very important financial item.

Let me give you an example of what I have in mind. Take the question of the requirement for the preventive children's dental service which is now in the act. We have looked into that in Group Health Association, and in my testimony we have a figure as to what we think the cost of this would be. But we have also found that preventive children's dental service is not a very meaningful service unless there is the followup treatment. And so we have to think about how we would meet the requirements of the act for Group Health Association, which is not Kaiser, but on the other hand has a hundred thousand members and already has a dental program, as an extra program that it is putting on.

Well, it would be a problem for GHA. But I suppose somehow or other we could meet the problem in GHA. But for a 5,000-member plan just getting underway, it would be an entirely different problem. They would either have to go out and hire a dentist and set up a dental unit—get the dental equipment and so on, all of which would be very expensive, or somehow or other they would have to go out and purchase this service in the community which also might be very expensive. This would place them in a situation where they are adding services before becoming financially viable, adding on services of this kind would be particularly difficult.

So, in the first place, the average figures, it seems to me, conceal the problem. And, second, it is not just a matter of the cost, but how they would actually be able to arrange for these services to be given. Therefore, it seems to me that until such time as we have the kind of national health insurance system which makes all of these benefits available to people, that a broad range of required services going far beyond what is called for in most private insurance contracts should not be asked of the HMO's.

Senator KENNEDY. Now, you also delete the alcoholism services, the home health services.

Mr. SEIDMAN. Again, I think, for example, that in GHA we could arrange to provide the alcoholism services. But for a new plan, it would be an entirely different situation, particularly if it was in a small community where there is no halfway house, for example, that is readily available, and where they would actually have to put people into hospitals for detoxification and so on. This could get to be a very expensive proposition.

Senator KENNEDY. These are obviously hard and tough decisions I am sure you are making. I think particularly with regard to the young people in our society, that is an extremely important health service, so these are really hard and tough decisions. I am sure you are as reluctant as we are to have to forego that kind of thing.

Mr. SEIDMAN. I certainly agree with you. As you know, Senator, the AFL-CIO has been concerned with alcohol and drug abuse programs.

We are doing everything we can to our community services program to deal with these problems. We think that to make this an absolute requirement on them in situations where they simply will be unable to provide this service I think is doing the wrong thing.

MR. SHOEMAKER. Mr. Chairman, I just want to add a comment to what Bert had to say. I will give my credentials too. I'm on the Executive Board of Group Health Association of America. I will say this; that speaking of the plans in the Group Health Association of America, they are strongly motivated to provide comprehensive care. The problem is the size of the mandated package. When these plans move forward to add additional things, additional benefits, with staffing to provide them, and when they get big enough so they will have enough use of this service, they do so. And the problem is the size of the mandated package, not the total of some of the benefits.

We would like to shift more of the mandated benefits to the optional supplemental package.

Senator KENNEDY. Well, why do we not go on?

Mr. Seidman.

MR. SEIDMAN. We have covered some of the sections of my testimony, and I will not repeat them.

On this question of the scope of benefits, I would like to call your attention, Mr. Chairman, to one very important report which has been issued. that is a report by the Institute of Medicine of the National Academy of Sciences, which issued a report entitled, very significantly, I think, "A Policy Statement, HMO's: Toward a Fair Market Test."

And they concluded, and I will only read one sentence from their conclusion:

The committee recommends that rigid requirements for comprehensiveness of benefits and services beyond basic outpatient and inpatient services not be imposed on HMOs in order that they can have the maximum flexibility in adapting themselves to the available resources and the needs of their communities.

It was the conclusion of the analysis by the Institute of Medicine that the present HMO law does not provide a fair market test.

For these reasons the AFL-CIO strongly supports the provisions of S. 1926 which would transfer home health services as well as alcohol, drug abuse and children's preventive dental care from the list of basic benefits to the optional supplementary list. We think it would also be desirable, in order to improve the competitive position of HMO's, to transfer mental health benefits from the basic to the supplementary package as well since many of our health benefit plans do not cover mental health.

We have already gotten into the question of open enrollment. Let me say while we have a problem with open enrollment, as I have already indicated, we are strongly in favor of community rating.

We do want to maintain the principle of community rating in the legislation and in the HMO program.

It is the combination of the two requirements in the HMO Act that we find very unfortunate and places HMO's at a very serious disadvantage.

Mr. Chairman, I would like to call your attention to the experience that Blue Cross had. Blue Cross of course was not required to provide services. It was really only required to provide financing for services, and therefore was in a more favorable position than the HMO's. But,

nevertheless, Blue Cross and Blue Shield found that with community rating that they used to have, the younger groups were shifting to commercial insurers and leaving high risk groups to the Blues. To preserve their competitive position, Blue Cross and Blue Shield have had to abandon community-rating. Now HMO's are called upon to community-rate in a sea of experience-rated contracts underwritten by both Blue Cross-Blue Shield and commercial insurance.

Nevertheless we want to maintain community rating so long as it is not combined with open enrollment.

The experience has shown that where HMO's have been in competition with the Blues and insurance companies, it was the insurance companies and Blues which enrolled the healthier patients and the HMO's are already—because they take in groups—enrolling patients with a larger amount of chronic illness and preexisting conditions of all kinds.

In my testimony I referred to a number of studies which have borne this out.

Senator KENNEDY. Let me ask you on this: We included the waiver in the legislation to deal with that very point. We have been listening to testimony making the point that you raised here. Now how would you feel about putting some kind of a maximum liability, for example, on the HMO's? Some kind of limitation on the numbers that they would have to take in, not excluding them completely, but permitting at least some kind of limitation so that they could deal with it, but not necessarily eliminating the responsibility to at least deal with this to some extent?

Mr. SEIDMAN. In other words certain percentage of their total membership—

Senator KENNEDY. Yes.

Mr. SEIDMAN. Go beyond individual members on open enrollment basis and then they would close their books?

Senator KENNEDY. Right.

Mr. SEIDMAN. Let me just say, Mr. Chairman, it is difficult for me to give an off-the-cuff answer to that. I would think that it would depend on what percentage we are talking about, and I have to consult with Group Health Plans to know and it seems to me that one possibility which the subcommittee might wish to consider is requiring—if the waiver possibility would still be included, and I assume it would be—is requiring the Secretary to give a determination within a certain specified period. I think this would be extremely important under the circumstances.

Senator KENNEDY. It seems to me we could do that. We set up under the Freedom of Information Act a required time in which they have to respond.

Mr. SEIDMAN. In practice, Mr. Chairman, if we did that, then the Secretary would have to give the waiver in a very short period prior to the open enrollment. I do not know whether that could be done on a practical basis or not.

Senator KENNEDY. Well, could we explore together the question about whether there is some opportunity to reach that kind of maximum liability requirement to see whether we cannot still accept in concept the principle of the open enrollment.

Mr. SEIDMAN. We would certainly be willing to explore it. We do not have any preconceived conclusions on it, however.

Mr. SHOEMAKER. Could I add a couple comments?

I appreciate the concerns about open enrollment and wish we had financing for everybody so we would not have to worry about it. But we do not have it. I think there are other dangers as well, Mr. Chairman, that we have to be aware of. If I am an individual, why should I take out any health insurance at all if I know that I am going to need some surgery, I will wait a little while—most surgery is elective—wait a little while until there is an open enrollment period, join the HMO, have the surgery and then quit.

Senator KENNEDY. Let me point out we are also providing some Federal money in this as well. If we are talking about sick people and talking about using taxpayer's money, and we are also talking about human beings, who have some decent kinds of interest in this—at least I am not just prepared to provide this organization an appropriation for this kind of shuffling around within the system, I think we have got to try and make some meaningful progress in some important areas. I think that what Mr. Seidman has indicated is a willingness to try to see if we cannot meet from a practical point of view some limitations on this, so we are not going to completely frustrate a whole system. You are coming in here and asking for changes in a system that has not even been tried yet. We are running out on the concept that has not even been tried yet. And ready to throw in the sponge on it. Let us try, if we are talking about the outlaying of funds in Federal taxpayer's moneys and others, to deal effectively. There are a lot of sick people being squeezed out. Let's try and see if we cannot provide some help and assistance for them rather than just throwing up our hands.

Mr. SEIDMAN. Mr. Chairman, we are not throwing up our hands. We recognize that this is a new program. If we thought that the program was going to be able to get under way as we are sure that you would like, and we know we would like, we would not be making these recommendations. We think that in the other avenue, working with you, to get a comprehensive National Health Insurance program, the Health Security Act, will open up these doors, that we insist should be opened up. We think that we are moving in this direction. But we do not think that without this kind of situation where we do have this kind of universal financing that the HMO's should be asked to bear a burden which they simply are unable to do.

They simply will not be able to get members from groups or anybody else. They will be performing much less of a service than they could do otherwise. That is why we are asking for these changes. The fact of the matter is that whatever may be desirable, there is no subsidization for these groups in terms of their day-to-day, month-to-month operating expenses. This has to be met entirely from the premiums that they can obtain from their members' groups or individuals.

If they find themselves as they may do with very, very heavy expenses because they are enrolling a large number of people with very, very heavy medical expenses, some of these groups simply will not get off the ground, and others that have already gotten off the ground may go under. Now we certainly would like to consider the idea that

you are suggesting. As I see it, it is difficult for us to give off-the-cuff answers, but we are certainly prepared to explore that idea or any other ideas which will maintain the principles of prepaid group practice, try to assure that the prepaid group practice programs and HMO's will provide maximum amount of service for the people of this country, while at the same time not saddling them with a burden that they simply are unable to bear.

Senator KENNEDY. Let us see what we can do. Obviously we are interested in limiting the burden on it. But there may be some ways of limiting the burden without completely eliminating that whole provision. I think if we had been able to provide the kind of direct grants to these HMO's and support for those that are accepting with open enrollment, offset some of the additional kinds of financial burdens, we would probably not be back here today. Hopefully we would not have been. But we have been unable to get that in terms of legislation.

So we are faced with this. We would like to try and work with you to see if we cannot work something out in those special areas where it is demanded. Let's see if we cannot reduce the burden on an HMO.

Mr. SEIDMAN. We do have some of a very brief specific recommendations.

Administrative costs do not justify requiring employers to offer the HMO option unless 25 employees or more reside in an HMO area. We support the provision in both H.R. 9019 and S. 1926 to accomplish this purpose.

We would hope that the Senate will make some improvements which are in neither bill. The recent Civil Service release clearly indicates the potential of HMO's to restrain the increase in medical care costs. We hope this subcommittee will consider making the HMO Act a permanent rather than a demonstration program.

We would also suggest that the authorizations provided in H.R. 9019 are too low and hope the Senate will increase them, especially for fiscal years 1977 and 1978.

In conclusion, Mr. Chairman, we urge early action on this legislation in order that more Americans will be given the opportunity of receiving their medical care from genuine HMO's which offer the most effective and efficient delivery system that now exists in the United States. We are convinced that HMO's will enjoy a health growth if they are given the opportunity to compete on even terms with fee-for-service. All that is necessary is a fair market test. We believe early enactment of legislation containing the main features of S. 1926 and H.R. 9019 with the changes we have suggested will provide for that fair market test.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much. We appreciate your presence here. Thank you for your testimony and we will include it all, obviously, in the record as read.

Mr. SEIDMAN. Thank you.

[The prepared statement of Mr. Seidman follows:]

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY
AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS
BEFORE THE SUBCOMMITTEE ON HEALTH,
SENATE LABOR AND PUBLIC WELFARE COMMITTEE
ON THE HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1975

January 19, 1976

Mr. Chairman, on behalf of the AFL-CIO I wish to thank you for the opportunity to present our views with respect to H. R. 9019, the House passed bill, and S. 1926, introduced with bipartisan support by Senators Schweiker, Javits and Mondale. We wish to commend you and the members of your subcommittee for considering the Health Maintenance Organization Amendments of 1975 so promptly after the House has acted.

S. 1926 is designed to amend the Health Maintenance Organization Act of 1973 to make it more workable and more practical. In fact, we would go so far as to say that unless Congress passes S. 1926, with the addition of two improvements which we are going to suggest, the great potential and opportunity that the HMO Act holds for improving the delivery of quality health services and of containing the escalation in medical care costs will not be achieved.

S. 1926 includes a substantial number of amendments to the HMO Act, some of which are technical in nature. Witnesses from the "Consensus Group" have testified in detail with respect to the need for these amendments which, with one exception, we generally support in their present form. Therefore, in the interest of conserving time and avoiding needless repetition, we will restrict our comments mainly to what we regard as the most important issues. These are: (1) the need for an additional amendment to clarify the intent of the so-called "dual choice" provision of the Act; (2) a modification in section 7 of S. 1926, which would amend section 1302(4)(c)(i) of the Act requiring the members of a medical group of an HMO to have as their principal professional activity the provision of health care for the prepaid enrolled members of the HMO; (3) reducing the mandated basic package of benefits under the present law; and (4) elimination of the open enrollment provisions of the present Act.

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Dual Choice

First, we wish to deal with section 1310 of the HMO Act, the so-called "dual choice" requirements of the law.

Let me say at the outset that amendment of this provision should not have been necessary. We do not believe that Congress had any intent when the HMO Act was enacted of utilizing this legislation to curtail, weaken or bypass the long recognized right of unions to bargain collectively on behalf of their members with respect to health and welfare benefits.

The problem that arose was not with the law itself but with the interpretation of the law that was rendered by the Department of Health, Education and Welfare in its proposed regulations dealing with section 1310 as set forth in the Federal Register of February 12, 1975.

Those draft regulations would have interpreted the HMO law to require the employer to offer a qualified HMO to the union as the bargaining representative for its membership even if the union, as the duly constituted representative of its members, decided that the particular HMO offered would not be in the interests of its members. In such case the employer would nevertheless have had to go over the head of the duly elected representatives of the union and offer the HMO option to his employees as individuals. The paradox of such a policy is that all experience with dual choice clearly indicates that the active support of the union leadership in promotional and educational activities of an HMO is essential to a successful enrollment campaign. Without the active support of the union the HMO simply will not fly.

Last year marked the 40th anniversary of the National Labor Relations Act. As President Meany stated on that occasion:

"These 40 years since President Roosevelt signed the National Labor Relations Act have seen greater progress toward the common welfare of all Americans and the growth of the nation's economy than any other period. The success of the institution of collective bargaining in establishing equity and peacefully resolving disagreements between employers and employees has made it the keystone of industrial democracy."

The proposed regulations would have bypassed the National Labor Relations Act and the Railway Labor Act. For this reason we requested an amendment to section 1310 of the HMO Act when we testified before the Subcommittee on Health of the House Interstate and Foreign Commerce Committee. As a result, the House did

incorporate an amendment on dual choice in H. R. 9019 which protects the right of unions to bargain on behalf of their members.

Since our testimony before the House subcommittee last July, the Administration has modified its position and the final regulations issued last month are quite satisfactory in this regard. However, because of the potential harm that could result if, at some future date, the regulations were changed, we urge that the amendment to Section 1310 now contained in H. R. 9019 be incorporated in any bill reported out of the Labor and Public Welfare Committee. It is essential that the issue be cleared up in the law and not just in the regulations.

When Dr. Cooper, Assistant Secretary for Health for HEW, testified before your subcommittee he recommended that Section 1310 should define "employer" by reference to the National Labor Relations Act and the Labor Management Relations Act rather than the Fair Labor Standards Act as in present law.

The AFL-CIO is opposed to this proposal. The definition of "employer" in the NLRA is too restrictive. For example, farm workers, government employees and other employees in industries that the National Labor Relations Board elected not to cover would be denied the benefits of Section 1310.

Requirements for HMO Medical Group (Section 7)

This section of S. 1926 eliminates the provision of the present HMO Act that would require a medical group to devote its professional time principally on behalf of the enrollees of the HMO. HEW has interpreted this requirement to mean that at least 51 percent of the time of the doctors in the group must be devoted to the HMO members. Certainly this is the minimum requirement that could have been set in accordance with the law. We see no reason for it to be eliminated. It is on this point that we differ from the Concensus Group which testified before your subcommittee on December 12, 1975.

The issue here is whether or not the medical group is committed to move in the direction of prepayment and capitation as the principal means of reimbursement.

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Without a majority of prepaid patients, all the advantages of budgeting and planning to meet the medical needs of an enrolled population virtually disappear. Where most patients go to a medical group for their care on a haphazard basis and pay for each service separately, the need for hospital beds as well as the number and kinds of physicians and other medical personnel needed cannot be determined with any accuracy. The ability to plan effectively and economically must rest on solid assumptions as to the medical care needs of a known population.

There are other dangers as well. If capitation is to be just another method of reimbursement for the medical group, income to the medical group may be maximized by retaining the more affluent patients under fee-for-service reimbursement while accepting the less affluent on a guaranteed income, i.e., under capitation. The fee-for-service patients become the preferred patients because they bring in additional income and the capitation patients do not receive equivalent consideration. This is not just theory. This has happened with one major prepaid group practice plan which has had to require its doctors, who had derived a large part of their income from fee-for-service, to devote their time mainly to the HMO members with payment by capitation.

With less than a full commitment to prepayment, an HMO may contract with a state for Medicaid eligibles and retain its wealthier patients on a fee-for-service basis. This would mean a two-class delivery system. We are strongly opposed to giving medical groups an economic incentive to maintain the two-class system. Therefore, we favor retaining the standard in the present law that a medical group serving an HMO should devote most of its time to providing health services for its enrolled members. However, in order to facilitate the conversion of fee-for-service multi-specialty groups to prepayment, we would favor phasing in this requirement over a period of five years just as the community-rating requirement in the present law would be phased in over five years by section 6 of S. 1926.

We recognize that in some few instances, a medical group may never, at least until such time as there is a comprehensive national health insurance program, be able to meet this standard. For example, a multi-specialty group practice may be located in a rural area with few employee-employer health benefit plans. In such case, it would be difficult for the medical group to provide most of its medical

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services to its prepaid enrolled members. Another example would be where one of the prestigious multi-specialty groups, such as the Mayo or Geisinger clinics, had such a large volume of referral patients that it could not meet the standard without giving up its referral patients -- obviously an unreasonable requirement.

The answer to this problem is, in our opinion, not to weaken the standard, but to grant the Secretary of HEW authority to make exceptions for good and sufficient cause.

We hope, therefore, that the subcommittee will retain this provision of the HMO Act but phase it in over a five year period and provide for exemptions by the Secretary upon a showing that the goal cannot reasonably be attained. This compromise was accepted by the House and has been incorporated in H. R. 9019. We urge this change in S. 1926.

HMO Benefits

In order to qualify for grants and guaranteed loans under the HMO Act as well as for the advantages of being able to market the HMO option under the dual choice provisions of the law, an HMO must provide its enrolled members a package of basic benefits. Under the present law, these basic benefits must include unlimited physician services, unlimited outpatient and inpatient hospital services, emergency medical services, short-term mental health services, well-baby care, family planning services, medical treatment for abuse or addiction to alcohol and drugs, home health services and diagnostic and preventive health services including preventive dental care and eye examinations for children. In addition, an HMO must provide medical social services, education services, education in the appropriate use of health services and education in the contribution each member can make to the maintenance of his own health.

There is not a single Blue Cross-Blue Shield plan or commercial insurance indemnity plan in the country that is providing anywhere near such a comprehensive range of services and there has been no proposal that they be required to do so.

As we stated in our testimony before this subcommittee on May 15, 1972 when the original HMO bills were under consideration:

"Prepaid group practice plans must provide comprehensive benefits in order to utilize the most appropriate method of treatment to

meet the medical needs of the patient in the most economical setting. At the minimum, therefore, comprehensive benefits must include, directly or by contract, outpatient and inpatient physician services including surgery and other specialized doctor care, inpatient and outpatient hospital services, diagnostic and other preventive care, routine rehabilitation and emergency health services. The premium for these benefits obviously must be higher than the premium for a limited insurance policy covering only hospitalization and surgery even though the HMO is more efficient. HMOs have to compete with the fee-for-service sector on the basis of what the consumer is willing to pay. As a practical matter, this means providing the broader range of services at the same price as the typical and limited medical-surgical-hospitalization package offered by Blue Cross-Blue Shield or commercial insurance."

Prepaid group practice plans can be highly competitive if they are not required to provide a scope of benefits far in excess of what is required of Blue Cross-Blue Shield or indemnity insurance. After the Civil Service Commission announced the premium rates for 1976 for all plans participating in the Federal Employees Health Benefits Act, the new family rates show that the Blue Cross-Blue Shield high option premium rate is more expensive than 36 of the 41 HMO-type plans that participate in the Federal program. Moreover, the average rate of increase over the 1975 premiums averaged 35 percent for the Blue Cross-Blue Shield high option family plan, 34 percent for the high option family indemnity plan (Aetna) but only an average increase of 19.3 percent for the high option family plan for 32 HMOs. All the HMOs provide preventive care. Blue Cross-Blue Shield and Aetna do not.

Had the HMOs participating in the FEB program been required to offer all of the benefits required by the HMO Act, their rates would have had to be higher than Blue Cross-Blue Shield.

Because the prepaid group practice form of HMO is more efficient than traditional insurance there is a real danger that they will be "loved to death." Every provider group wants to be included in the mandated benefit package. Every provider group claims that to include its services will not cost much. But every additional required service is like another straw on the camel's back.

It costs very little more to provide unlimited hospitalization as compared to 365 days of coverage.

It costs very little to have no extra charges for physician services.

Short-term mental health services do not cost much.

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Home health services are inexpensive.

Family planning services are a minor item.

Well-baby care can be provided by pediatric nurses.

Treatment for addiction to drugs and alcohol can be provided at minimal cost.

Preventive dental care for children does not cost much money.

Each of these services, taken alone, won't financially break a prepaid group practice. But taken together, all of these little straws now amount to a haystack on the HMOs' back.

In a recent study "Comparison of Costs of HMOs under the HMO Act of 1973, Other Prepaid Health Plans, and Group Health Insurance in Selected Metropolitan Areas" conducted by the General Research Corporation and prepared for the Office of Planning, Evaluation and Legislation, Health Services Administration, estimated the total cost for the mandated benefit package under present law for prepaid group practice plans as \$24.88 for a single person, \$51.38 for a family of two and \$86.44 for a family of three or more.

This cost exceeded the highest premiums for traditional group health insurance in all of the nine cities surveyed. Since the HMO Act allows copayments up to 20 percent of costs, actual premium rates charged by the PPGPs were lower than the total cost figures cited above. Nevertheless, the premium rates for the prepaid group practice plans exceeded the top premium rate for traditional insurance in four of the survey cities and were among the highest in the other cities. And in all cities, the PPGP premium was substantially higher, sometimes twice as high as the lowest premium for traditional group insurance.

The HMO Act requires 20 percent of the sums appropriated for HMOs be set aside for rural HMOs. The Marshfield Clinic in Wisconsin serves a rural population. When this medical group offered to enroll the population it previously served on a fee-for-service basis, only 40 percent could afford to sign up. The Marshfield Clinic is the only source of medical care for this rural population. The result was that 60 percent of the population had to continue to receive episodic care on a fee-for-service basis or no care at all because that was all they could afford. No wonder there have been few applications to develop rural HMOs.

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The benefit package is not the only problem. The comprehensive benefits mandated for a qualified HMO limit the opportunity for an HMO to tailor benefit packages to meet the specific needs of different groups within the framework of what such groups can afford. Traditional health insurance plans have developed their benefit packages to meet the needs and pocketbooks of their subscribers. To deny HMOs the same flexibility places them at a serious competitive disadvantage.

The cost of a drug and alcohol abuse program cannot be precisely determined at this time. There is too little experience with the benefit. However, it is a certainty that if a developing HMO cannot finance a half-way house or utilize an existing one for detoxification, it will have to send patients to an expensive hospital for that purpose and the cost of an alcohol and drug abuse program could then be substantial.

With respect to preventive dental care for children, this service is not a negligible item. Group Health Association, Inc. here in Washington, D. C. estimates the annual cost at \$35.90 per child or \$16.12 per subscriber contract. However, a dental program limited to preventive care does not make very much sense. You have to have about the same amount of floor space and the same capital expenditures for dental chairs and other equipment as you would have to have for a full program. Moreover, any self-respecting dentist is not going to have much enthusiasm about having his talents wasted on examinations, oral prophylaxis, topical fluoride application and surface sealant services. He prefers to follow up on the preventive care, when required, with necessary treatments and restorations. Recruitment of qualified dentists would be most difficult in such circumstances.

The most important consideration is, however, that a developing HMO cannot afford to provide these services. An established HMO with more than 100,000 subscribers will have a sufficient number of members needing the service to justify hiring staff. However, the developing HMO with 5000 members or less would have such a small demand for certain types of care that the capital expenditure and the payroll required to provide the little used service would be very burdensome to such an emerging HMO.

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The scope of basic benefits mandated for qualification under present law would be feasible under a comprehensive national health insurance program such as the Health Security bill (S. 3) which you have introduced, Mr. Chairman. In that event, all U. S. residents would have comprehensive benefits. In such a climate HMOs would prosper and grow. However, Congress has not yet enacted Health Security.

An alternative approach would be to provide a premium subsidy for low and middle income groups. We include middle income groups since the cost of the basic HMO benefit package under present law is about \$85 a month for a family, a substantial premium. We do not anticipate that Congress would be willing to provide a premium subsidy at this time and even if it were, such a subsidy would certainly invite a veto by the President.

It, therefore, appears that the only feasible alternative at this time is to provide a mandated benefit package which will not be so expensive that HMOs, and particularly those getting under way, will not be able to compete with private insurance.

The prestigious Institute of Medicine of the National Academy of Sciences in its report, "A Policy Statement, HMOs: Toward a Fair Market Test" stated:

"Although most HMOs are designed to provide a wide range of health services, there are reasons why the range should not be too closely dictated by legal and administrative requirements. For example, in the beginning stages of development, an HMO could find it difficult to provide all of the services that it may ultimately wish to offer. Small HMOs will find it difficult to offer certain kinds of benefits. Moreover, the HMO's ability to attract enrollees may actually diminish as it increases the number of services which the consumer must obtain within the HMO rather than outside it. For example, if the enrollee has a dentist whom he does not wish to give up, he will be less likely to join an HMO if dental services are included in the benefit package. As long as health insurance is voluntary, the HMO must be able to compete in the health care market where the attractiveness of a plan will be considered in terms of the potential enrollee's financial ability and willingness to pay.

"The committee recommends that rigid requirements for comprehensiveness of benefits and services beyond basic outpatient and inpatient services not be imposed on HMOs in order that they can have the maximum flexibility in adapting themselves to the available resources and the needs of their communities."

It was the conclusion of the analysis by the Institute of Medicine that the present HMO law does not provide a fair market test.

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For these reasons the AFL-CIO strongly supports the provisions of S. 1926 which would transfer home health services as well as alcohol, drug abuse and children's preventive dental care from the list of basic benefits to the optional supplementary list. We think it would also be desirable, in order to improve the competitive position of HMOs, to transfer mental health benefits from the basic to the supplementary package as well since many of our health benefit plans do not cover mental health.

Community-rating and open enrollment

The AFL-CIO is strongly in favor of community-rating. We also favor the principle of open enrollment. But the combination of the two requirements in the HMO Act is very unfortunate and places HMOs at a very serious disadvantage.

Blue Cross and Blue Shield originally adopted the principle of community-rating when there was little competition in the health insurance market. However, when the commercial insurance companies entered the market, they followed their traditional business practice of experience-rating their contracts. The result was predictable. The private insurers were able to quote a lower rate to relatively young employee groups than the Blue Cross-Blue Shield community rate. Younger groups shifted to the commercial insurers leaving the high-risk groups to the "Blues." To preserve their competitive position, Blue Cross and Blue Shield have had to abandon community-rating. Now HMOs are called upon to community-rate in a sea of experience-rated contracts underwritten by both Blue Cross-Blue Shield and commercial insurance.

The prepaid group practice plans have had more success in maintaining community-rating. Because their costs are lower as compared to their competitors for a comparable package of benefits, they have been able to compete with other insurers. In order to do this, however, the existing plans have had to limit open enrollment to members of groups, and individuals are accepted only after a screening. Nevertheless, prepaid group practice plans have been subject to adverse selection.

In a study made by the University of California at Los Angeles School of Public Health which compared the characteristics of the enrolled population of commercial insurance plans, Blue Cross-Blue Shield and prepaid group practice

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plans, it was found that prepaid group practice plans had a higher proportion than the other two of enrollees who were older, had more chronic conditions, had lower income and were of minority groups. The findings with regard to chronic illness were particularly illuminating. Among the families enrolled in the commercial insurance plans 62.4 percent had no chronic illnesses reported in the year prior to the study; 53.4 percent of the families enrolled in Blue Cross-Blue Shield reported no chronic illness; but only 39.4 percent of the families enrolled in the group practice plan reported no chronic illness.

Likewise the commercial insurance plans had only 24.6 percent of their enrollees over age 41, Blue Cross-Blue Shield had 38.8 percent while the prepaid plans included 35.9 percent over that age. The study came to the following conclusion:

"Analysis of the membership compositions of the three types of health insurance plans indicates that the commercial plans enroll persons with the lowest risk of sickness (and demand for medical care) whether measured by age levels, symptom-sensitivity or past history of chronic illness -- especially the latter. The next level of risk is found among persons enrolled in the provider plans (Blue Cross-Blue Shield), while the highest level of sickness risk characterizes the members of the group practice plans."

Even when the premium rates for an HMO are comparable to those charged by Blue Cross-Blue Shield, the fact that preventive care is included in the HMO benefit package and that there is less in the way of out-of-pocket expenditures by the subscribers results in adverse selection. Large families, older people and those afflicted with chronic disease find the HMO more appealing.

Where employees have to make a contribution toward the premium cost of an HMO, adverse selection becomes even more of a problem. The MedCenter Health Plan in Minneapolis-St. Paul, Minnesota just completed a study among its enrollees and found that health plan utilization increased in direct relation to the additional amount employees are required to pay to join the HMO over and above what they have to pay for their regular health insurance plan. The MedCenter Health Plan concluded that for MCHP to compete successfully in the marketplace against competing indemnity insurance carriers and other HMOs it cannot rely on its full comprehensive benefits and provider reputation alone to sell its services. It must be able to offer a set of prepaid benefits structured in such a way as to allow competitive pricing.

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If HMOs are required to community-rate and at the same time maintain a policy of open enrollment, few are going to survive. The prepaid group practice form of HMO has been a major American contribution to solving the problems associated with the delivery of health services. What a paradox it would be if the law that was designed to help them grow actually caused them to fail!

Because of the critical importance of eliminating the open enrollment requirement in the present law, the Group Health Association of America wrote to their member plans requesting information with respect to their experience with open enrollment. It must be recognized that relatively few prepaid group practice plans have conducted wide open enrollment campaigns such as required by the HMO Act. Nevertheless, the GHAA survey is indeed frightening to those who believe in prepaid group practice. The results of the survey were commented upon by Thomas O. Pyle, Executive Vice-President of the Harvard Community Health Plan, before your subcommittee on December 12, 1975. Because of the importance of this survey, we wish to quote from his statement:

"The Community Health Care Center Plan in New Haven, Connecticut allowed elective membership, or open enrollment, through a Consumers Cooperative. Despite a six month waiting period for membership, the ambulatory utilization rate was 145% that of their regular members, and the hospital utilization rate was almost 5 times as high. At that same Plan, conversions from group membership to non-group membership, that is, people who elected to continue coverage when they left their job, had an ambulatory utilization rate 1-½ times, and a hospitalization rate of almost three times, those for all members of the Plan.

"Similar data is found in other situations. The Arizona Health Plan in Phoenix, Arizona, among group conversions had a fifty-six percent higher visit rate. North Care, in Evanston, Illinois, conducted an open enrollment period immediately after beginning operations. The per capita cost of those enrollees is 37% higher than the average in the Plan. The Marshfield Medical Foundation, Marshfield, Wisconsin openly enrolled individual members, and found a per capita cost which was 37-½% higher than the average of all their members. Blue Cross-Blue Shield in New Jersey, an indemnity type plan, conducted an open enrollment in 1973. There was a 12-month waiting period before pre-existing conditions were covered. The cost in the first year was 35 to 40% higher than the average of all members; after 12 months it went up to 60% above the average.

"In 1960, the Health Insurance Plan of New York, in New York City, conducted an enrollment which, while ruling out people with such diseases as cancer and tuberculosis, was essentially an open enrollment. The enrollees were significantly older than the average HIP membership; they had a 70% greater physician utilization rate in early years. More recently, this has come down to a 40% higher physician utilization rate and a 30% higher hospitalization rate. Screening these initial members would have kept about 40% of them from joining, using the traditional criteria applied in issuing health insurance. It should be noted that the HIP utilization figures I have just quoted cover a span of 12 years, from 1960 to 1972. This is a clear indication that heavier utilization is not purely a start-up phenomenon, as some would argue.

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"Under an HEW Grant to provide health care to the near poor, the Harvard Community Health Plan openly enrolled 1,000 individuals. Their hospitalization was double that of the rest of our members, and the ambulatory utilization rate was 25% above. One woman was enrolled by her family while she was in the hospital with a stroke.

"Incidentally, just a bit more on the reject rate -- the Ross Loos Medical Group in Los Angeles, California, in a recent sample of 60 applicants, rejected 15 and accepted 5 with waivers. This gives you some idea of the proportion that would want to come in under an open enrollment.

"The Group Health Plan of St. Paul, Minnesota, does not openly enroll, but it does offer non-group membership to group conversions. It has had no direct enrollment on a non-group basis since 1973 because of the higher utilization of this group. To quote their General Manager, Maurice J. McKay, with respect to non-group conversions, "In 1973 these people utilized 25% more services per person than those covered under our group contract, and in 1974 this percentage has increased to 30%."

It would be naive not to expect insurance agents to refer individuals who could not otherwise obtain health insurance, the so-called "uninsurables," to HMOs under the open enrollment provisions of the present law. Indeed, it is our understanding that this is exactly what took place in Evanston, Illinois, where the Northcare Plan has just really gotten underway.

It would stretch the imagination of reasonable men not to expect fee-for-service physicians to refer to HMOs older patients with chronic disease and who, from a treatment standpoint, many doctors consider uninteresting.

About five percent of the U. S. population is enrolled in HMOs. This small group cannot underwrite the medical-financial disasters of 100 percent of the population.

It is significant that the American Medical Association opposed elimination of the open enrollment provision in its testimony before the House. Undoubtedly, they will also oppose it today. We hope this subcommittee will forgive us the observation that we are highly skeptical that the AMA has suddenly become socially conscious. Their motive is the desire to preserve fee-for-service reimbursement and to see HMOs fail. We believe this subcommittee will see through their plan.

We would point out, as well, that the social consciousness of the AMA only applies to HMOs and not to themselves. The AMA has always defended the right of physicians to refuse patients.

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We strongly favor retaining the principle of community-rating. But to do this, the provision of the HMO Act requiring open enrollment must be deleted. Both H.R. 9019 and S. 1926 do eliminate the open enrollment provisions of the present law and we strongly urge this provision be retained in the bill your committee will report unless your subcommittee is prepared to require community rating and open enrollment of all health insurance organizations.

Miscellaneous

Administrative costs do not justify requiring employers to offer the HMO option unless 25 employees or more reside in an HMO area. We support the provision in both H.R. 9019 and S. 1926 to accomplish this purpose.

We would hope that the Senate will make some improvements which are in neither bill. The recent Civil Service release clearly indicates the potential of HMOs to restrain the increase in medical care costs. We hope this subcommittee will consider making the HMO Act a permanent rather than a demonstration program.

We would also suggest that the authorizations provided in H.R. 9019 are too low and hope the Senate will increase them, especially for fiscal years 1977 and 1978.

In conclusion, Mr. Chairman, we urge early action on this legislation in order that more Americans will be given the opportunity of receiving their medical care from genuine HMOs which offer the most effective and efficient delivery system that now exists in the United States. We are convinced that HMOs will enjoy a healthy growth if they are given the opportunity to compete on even terms with fee-for-service. All that is necessary is a fair market test. We believe early enactment of legislation containing the main features of S. 1926 and H.R. 9019 with the changes we have suggested will provide for that fair market test.

Senator KENNEDY. Our next witness is Dr. Edgar T. Beddingfield, Jr., vice chairman, American Medical Association, Council on Legislation.

STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D., VICE PRESIDENT, AMERICAN MEDICAL ASSOCIATION COUNCIL ON LEGISLATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION, AND DAN HILL, ASSISTANT DIRECTOR, DEPARTMENT OF LEGISLATION

Dr. BEDDINGFIELD. Mr. Chairman, I am Edgar T. Beddingfield, Jr., M.D., a physician in active practice in Wilson, N.C., and vice chairman of the Council on Legislation of the American Medical Association.

Accompanying me today on my immediate right is Harry N. Peterson, director of the department of legislation. On his right is Mr. Dan Hill, assistant director of our department of legislation.

Mr. Chairman, we are pleased to be here today to submit the views of the American Medical Association on S. 1926 and H.R. 9019, the Health Maintenance Organization Amendments of 1975. The bills would amend Public Law 93-222, the Health Maintenance Organization Act of 1973, enacted in December of 1973.

The present HMO Act was passed by Congress amid a high level of congressional expectations. Testimony presented to Congress at the time of its consideration was extensive, and testimony in favor of HMO enactment generally supported implementation of a comprehensive program. In general, comments ranged from support of the HMO as the panacea for health care, to cautious optimism, to views that such a program was unwarranted or that only experimental entities should be funded, if any.

Congress considered HMO legislation for a period of almost 3 years prior to passage of Public Law 93-222. Many House and Senate bills were introduced and considered. Extensive public hearings were held during which a variety of models of HMO's were proposed and were considered. Eventually Congress sifted through this mass of material. After evaluating those characteristics presented as essential to an entity to be recognized as an HMO, the Congress enacted a statute which spelled out quite specifically the details of what an HMO should provide in order to accomplish the HMO objectives, and also established the mode of operation under which the HMO should provide such comprehensive health care.

The Senate committee report, issued with the passage of its version of an HMO bill, reflects congressionally perceived arguments in favor of the desirability for HMO's. We note in the report, in support of the proposed HMO, that there was a great emphasis upon pointing out that the development of the HMO would "accomplish several worthwhile goals."

For example, the report states as an advantage of an HMO the elimination of problems encountered when:

Patients must seek uncoordinated care from various specialists who may be scattered over a wide geographic area, necessitating a number of time-consuming visits to more than one doctor.

In addition, the report emphasized the desirability of full comprehensive services, open enrollment and community rating, with round-the-clock accessibility of services

When Public Law 93-222 was passed, the act reflected concerns and expectations of Congress as indicated in the House report, the Senate report and the conference report. Support for the passage of an act also came from the administration, which had used earlier nonspecific authority to develop and to fund 110 HMO experiments, but had, according to the House report, discontinued funding new projects "due to objections by the Congress to the conduct of such a large demonstration without specific legislative guidelines * * *"

I would now like to outline, briefly, some of the "legislative guidelines" which were expressed in Public Law 93-222.

The act first states that an HMO is an entity which (1) "provides basic *and* supplemental health services to its members" in the manner prescribed by the act, and (2) "is organized and operated in the manner prescribed" by the act [emphasis ours]. Among the requirements spelled out in providing services, the act specifies that premiums for basic and supplemental services must be based on "a community rating system" and that basic services be provided by health professionals "who are members of the staff" of the HMO or through a medical group or individual practice association. A medical group is defined by the act in part as a group whose members "as their *principal professional activity* and as a group responsibility engage in the coordinated practice of their profession for a health maintenance organization" [emphasis ours].

As to the method of operation of an HMO, the act requires that there be an open enrollment period of at least 30 days each year.

The act then defines basic services to include physician services, hospital services, emergency services, certain mental health services, services for abuse of, or addiction to, alcohol and drugs, laboratory and radiologic services, home health services, and preventive health services—to include at least four specified services. Supplemental services are defined to include nursing home care, vision care, dental services, mental health services, physical medicine, and rehabilitative services and prescription drugs.

The language of the act then establishes funding for grants and contracts for HMO's and for loan guarantees to entities to serve "a medically underserved population," funding for operating costs of HMO's and for loan guarantees for costs of HMO's serving "a medically underserved population," and allocates general appropriations ending June 30, 1977.

Another section of the act establishes the requirement for all employers of certain numbers and types of employees to provide, as part of any health plan offered, an option to its employees for membership in a "qualified health maintenance organization." Other sections of the act establish a program of formal evaluation, annual report requirements, and quality assurance studies.

During congressional consideration of the need for Federal support for an entity to be called an HMO, a variety of testimony was submitted concerning whether an HMO mode of health care delivery existed at that time. It was our view that the HMO, as such, was a creature of statute, and until defined by the Congress its existence could not

be ascertained. We were quite surprised when it was stated, in the House report, that such a system did indeed exist, as follows:

HMO's have existed in this country for over 40 years and presently serve more than 7 million people. During this long period of operation they have been carefully studied and there is much evidence that they serve to alleviate many of the problems listed above—rising health care costs, accessibility to medical care, effective quality control, orientation toward acute care rather than maintenance * * *.

The Senate report also recognized a long history of HMO existence by stating:

There exist 20 prepaid health plans which would qualify structurally as health maintenance organizations * * *. They currently have a total enrollment of in excess of 4 million individuals * * *. Some of these plans have been in effective operation for over 40 years.

We are, quite frankly, now additionally perplexed by the apparent inconsistency between the determination, on one hand, that a legislative program was needed to test a delivery mode based on so many years existence, serving so many millions of people, having been so carefully studied, and having shown so much evidence of being able to solve so many problems, and, on the other hand, its proposed abandonment after only 2 years' "demonstration."

Senator KENNEDY. You are very much aware that myself, and I think the majority of the members of this committee, never felt that it should be a test program. We passed the HMO legislation, probably three different times at least, before we were able to get health action on it. It was never intended or mentioned at the time that it was to be a test program. If I understand, it was more the position of the AMA that it be a test program rather than this committee or the Senate of the United States. Would your position be any different if we were to make it a permanent program?

Dr. BEDDINGFIELD. The position as far as the Federal subsidy might be considerably different.

Senator KENNEDY. In what respect? Do you think you would support it?

Dr. BEDDINGFIELD. No; I do not think we would support it. We should await the conclusion of the demonstration. I believe that we develop some of these points later on. I am only about halfway through my paper if you will let me complete it.

Senator KENNEDY. Sure.

Dr. BEDDINGFIELD. However, irrespective of the findings by Congress and the deliberately detailed language of the present act purposely establishing a comprehensive program deemed to be essential to an HMO, and notwithstanding the recently expressed congressional certainty for the need for the present program, far ranging amendments to the HMO Act are now proposed.

Mr. Chairman, in our view the proposed amendments are major and would effectively gut the HMO concept and subvert the original intent of the present act by converting what were viewed as the minimal essentials for an HMO into a program which would carry forward the initial act in name only.

These proposed amendments would make many changes in the act. However, special concern must be given to certain extremely important amendments which, if passed, would go far in eliminating the

initially perceived necessity for establishing these experimental programs in the delivery of health care.

First, the items included in basic services and supplemental services would be redefined by the amendments. Basic services in the present act would be changed by S. 1926 by eliminating services for alcohol and drug abuse, as well as home health services, both of which would be transferred to supplemental services. Basic services in S. 1926 would no longer provide generally for preventive health services, but would be defined as including specific services. Any other preventive services would, if offered at all, be covered under supplemental services. H.R. 9019 does retain home health services as well as general preventive health services in its definition of basic services but also, like S. 1926, drops inclusion of medical treatment and referral of alcohol and drug abuse patients.

Senator KENNEDY. Is it your feeling that with the dropping of those particular programs then they would be competitive with other programs?

Dr. BEDDINGFIELD. No; I do not believe it should help make them any more competitive. First, we have already heard this morning these programs are not great costly programs. Second, if the cost savings inherent in the HMO model are indeed true and valid, as you have heard repeatedly, I think that these cost savings should be returned to the enrollees of HMO in the form of extra benefits or lower premiums.

Senator KENNEDY. Well, I have my own opinions about how much it is going to save. But those who are very much involved in those particular programs believe that there would be important savings. I am just wondering whether your people, since you commented on it, have worked out any cost figures.

Dr. BEDDINGFIELD. Obviously, of the people enrolled in HMO's, a certain number are going to have these problems. They are going to need home health services. They are going to need alcohol and drug service. Where are they going to get them? Does that mean they are going to, who some have called the worn and weary, inadequate fee for service physician and get those services outside of HMO? This adds to their total cost, in addition to the HMO cost. The fact that HMO does not offer the services does not mean that they do not get the services or do not need the services.

Senator KENNEDY. What is happening today? Where are they getting them?

Dr. BEDDINGFIELD. I am inclined to believe they are getting service from the private sector, through what we like to call the pluralistic approach, some from health departments, some from private physicians, some from municipal hospital outpatient departments, and ad infinitum. The funny thing is that the system works.

Shall I continue?

Senator KENNEDY. Yes.

Dr. BEDDINGFIELD. Second, and one of the most devastating changes, is the amendment making the provision of supplemental services merely an option with the HMO. As you recall, the present act, in section 1301, requires that all services enumerated in the supplemental health services option of section 1301, must be offered to each member of the HMO for coverage on a prepaid basis. The member may elect

such coverage. The idea, of course, was that the HMO, unlike other modes of delivery then being criticized, would make available all necessary health services. The present amendments, however, would not require the HMO even to make the offer to the member. Furthermore, it provides that if a supplemental health services option is offered, only those services which the HMO selects from those enumerated in the act need be included.

We note that the HMO concept has been advocated to the public as being designed to switch the focus from hospital to ambulatory health care, and to provide greater emphasis on both primary care and preventive medicine, to improve the Nation's medical care, and to accept the responsibility at all times for providing its members with needed care to assure those members available, accessible care and to assure its continuity. The HMO, in providing a full range of health services, was advanced for the purpose of, and was initially designed for, keeping the patient well and not for treating illness. Now, however, the present amendments are advocated as needed "so that HMO's can effectively compete in the marketplace."

It should be remembered that competitiveness should not be determined alone on the basis of premiums charged. In this regard the House report states:

With regard to controlling rising health care costs, the committee has been presented with data which shows that, while the premiums for an HMO may be greater than those for an insurance plan, the total costs to a family will be less in the HMO because the benefits provided by the HMO are more comprehensive * * *.

In view of the modifications proposed which would water down or eliminate the earlier HMO requirements then deemed essential we find ourselves forced to ask this question directly at this time: Is it no longer desirable or necessary to furnish all the care needed by the enrolled member?

If in fact the foregoing cited statement is correct, will the proposed reduction of comprehensive benefits, which undoubtedly will reduce the premiums, now have the adverse effect of increasing the total out-of-pocket expense of the HMO members? And to pose the question another way, will not the patient have to look beyond the HMO for his needed care, contrary to the basic principle of the HMO? In addition, we would suggest that the committee might also consider the effect on the enrollee of the regulations which provide for imposition of coinsurance in the provision of services, and permit the supplemental services to be furnished on a fee-for-service basis.

Third, provisions of the act which require premiums to be established under a community rating system, viewed at the time of enactment as of prime necessity to an acceptable program, would be amended to allow deferral of this essential feature. And it should be noted that, while the amendment is in terms of a 5-year deferral, the federally supported entity may never be required to community rate. This is so because the deferral is for up to 5 years after the date upon which an entity becomes a "qualified health maintenance organization" as defined under section 1310 of the act, relating to employees health benefits plans. There is no assurance that any particular HMO would ever become a "qualified health maintenance organization," and consequently the deferment could, as to some entities, be permanent.

Experience rating—the alternative to community rating—would defeat the objective of risk spreading sought to be achieved through community rating.

Fourth, the requirement that there be an annual open enrollment would be deleted. This would effectively assure that the entity could select its members and would not have to accept unfavorable risks. This, of course, would have the effect, desirable from the point of view of the HMO, of lowering the premium and presenting an ostensibly more favorable program. Such a change would authorize an HMO to engage in "skimming." A reading of the Senate committee language, strongly condemning the practice of "skimming," makes clear the attitude of the committee:

The committee hopes the inequities inherent in "skimming" and in experience rating can be avoided in this new Federal program (by providing for uniform rates and open enrollment).

Senator KENNEDY. I am interested in hearing your comments about skimming and about the problems between open enrollment and experience rating. Can you tell us what the AMA has done to object to this kind of policy by the private sector, the insurance companies, for example, over the period of the last umpteen years, when they have been involved in this very same practice?

Dr. BEDDINGFIELD. Yes, AMA has had an ongoing program—

Senator KENNEDY. Where have you objected to their practices and procedures? Just so we find out the consistency of the AMA position, can you supply us with information where you have indicated that the AMA has met with the insurance companies, objected to it, and filed statements and comments in opposition to this?

Dr. BEDDINGFIELD. Yes, sir. We have extensive documentation over the years. The actions of our governing body the House of Delegates, for example, which have been taken. For example, alcoholism, including chronic illness insurance programs. And perhaps it is best exemplified by our own version of a national health insurance plan which provides for open enrollment in that. We are on the record with that, sir.

Senator KENNEDY. With the Federal subsidy, is that right?

Dr. BEDDINGFIELD. For the poor.

Senator KENNEDY. For the high risk people?

Dr. BEDDINGFIELD. No. I do not know that risk is related to subsidy in the AMA bill.

Mr. PETERSON. Mr. Chairman, there is no subsidy in the program except insofar as there would be a subsidization of the premium which would be related directly to the income of the individual. It has no bearing with respect to the physical condition of the individual, toward which skimming of course is directed. The subsidy that is provided in the AMA national health insurance bill is related to the income of the individual. There is open enrollment provision in the bill.

Senator KENNEDY. How does a chronically ill person afford health insurance under the AMA program?

Dr. BEDDINGFIELD. It would depend upon his economic level. He could purchase insurance; if he had been employed, his employer could provide it. If he had not been employed, he could purchase it if he were financially able. For the borderline economic individual, there is a partial Federal subsidy envisioned. And if he were indigent, he would be totally subsidized. The Government would pay his insurance

program for him. This is the way it is envisioned. There is no limitation on maximum benefits. It includes a catastrophic kind of concept in addition to basic benefits.

Senator KENNEDY. Well, I am interested in the strength of the comment that you are talking about in open enrollment, in how experience rating and skimming is so bad. I personally agree with the fact that it is bad. We were trying to deal with that with open enrollment which would permit direct support to the HMO's, in offsetting any kind of increased price. We never heard one word from the AMA regarding support for that particular proposal.

It is interesting to listen to you talk about your opposition to any retreat on that particular proposal because when we had something that would really be meaningful in dealing with that, the AMA was silent.

Dr. BEDDINGFIELD. Mr. Chairman, if I may respond; at the time you considered this HMO bill which you are now attempting to amend, there were already quite a number of experiments abroad in the land, which experiments had not been completed. We did not feel that it had been demonstrated—I think our reservations are echoed in testimony that you have heard from GAO and Dr. Cooper in particular—that it is really true that this is a better mousetrap. Is it really true that substantial cost savings can be achieved, that higher quality services can be delivered, a bigger package of benefits without skimming? Now all of these are things that have been claimed by the advocates for HMO's. Does this better mousetrap exist in fact, or now are we going to change the blueprint of the better mousetrap so that it is a little smaller mousetrap, which you can charge more for, and you can only take healthy rats into? This is our argument. This is a demonstration. It has not been proved.

If they save all this much money, if it is 20 or 30 percent cheaper than fee for service medicine, where does this money go? What do they do with it?

Why do they want to cut back benefits now?

Why do they only want to take healthy people?

We think this is a valid point of view. This is what we are trying to get across to the committee.

Senator KENNEDY. I understand what you are trying to get across to the committee. I was directing this to the particular point No. 3 about open enrollment experience rating, and your concern about skimming and other practices. Where have you been all this time? Where was the AMA when the committee was attempting to deal with an open enrollment program, which would have provided some direct Federal subsidies. This Committee dealt with that in the period of the markup, where we said open enrollment would provide additional financial burdens on the HMO, and, therefore, we were going to provide some direct Federal subsidy to permit them to continue to compete in this area, then we were unable to carry that particular issue. We have open enrollment now, with the testimony and comments about whether they can effectively compete because of the fact there is skimming going on by the insurance industries, but then you come up here and say that you are very much bothered by the questions of skimming and experience rating. But when we really had the chance to do something

about it, we had silence or opposition by the AMA on this particular point.

That is why with all due respect your crocodile tears about this particular feature are somewhat troublesome in terms of the credibility of the AMA on that particular issue. If I am wrong or inaccurate in stating the history and the position of the AMA, I would be glad to have the record show what your position is.

Dr. BEDDINGFIELD. I can only respond in this fashion, Mr. Chairman. If the HMO does not find it necessary to skim, and they can operate in what has been called a fair market test, then they ought to do it without Government subsidy. If they are going to get these Government subsidies, they ought not be equated in enrollment practices and rating procedures and benefit package with the private companies. If they are going to reduce themselves to what the private sector does, then why are they up here asking for Federal money?

Senator KENNEDY. Does it not come down to whether you are going to be able to offset those expenses or not? Is that not the issue? The question is whether you can make that judgment from an actuarial point of view. We are prepared to do that from an actuarial point of view. If they are going to have to have more for treating people that are sick, who are being turned down because of experience rating by the insurance companies, then they should be able to be augmented or supplemented. So you do not have the kind of problem that you are evidently objecting to. When this committee was trying to do something on that particular issue, the AMA was just not there. You were not up here either helping us or trying to fashion some kind of proposal or giving us the benefit of the judgment in terms of cost. All you were doing quite frankly is out scuttling the legislation, unless Dr. Kernodle's article in the Wall Street Journal in 1973 is mistaken, where they indicate quite clearly what your position was. Is Dr. Kernodle's position in the Wall Street Journal which indicates a general kind of opposition to the whole program still AMA policy?

Dr. BEDDINGFIELD. I do not know since I have not recently read the 1973 back issues of the Wall Street Journal, so I cannot comment on what Dr. Kernodle said at that particular time.

Senator KENNEDY. It is not back issues. He is a fairly significant figure in your organization or was.

Mr. PETERSON. In 1973 I think the record will show in connection with the HMO history and presentation before the committees, there was considerable activity by the Government, by the administration, in the HMO field, in subsidizing through grants at that time, the development of HMO's. Our testimony will show very clearly that we supported that demonstration program, and we are here today again calling for a completion of the demonstration program.

So I would want to say very plainly that the association's position is that the HMO may have a role in the pluralistic delivery of health care, and the association strongly supports this pluralistic system. But the point that we want to make very clearly is that the HMO had throughout the legislative history claimed certain advantages, and we would like to see those advantages demonstrated in the manner as was finally resolved by the Congress. We are calling for completion of this act.

Now if the subsidies that the chairman has referred to, to enable HMO to provide this additional care that you are referring to, if there is going to be competitiveness in the market, then it would seem that there would have to be similar subsidies to the private insurance companies for the elimination of the practice that is being referred to as skimming.

Senator KENNEDY. My memory goes back to Malcolm Todd in the summer of 1972 when he was personally taking credit for ducking the HMO legislation. If you want to make representation here that would indicate or suggest that there is anything but that kind of a positional policy, you are free to do so. But my memory is somewhat longer than this.

Mr. PETERSON. One last word, if I may, Mr. Chairman. Just to indicate, as you are very familiar there was a wide variety of bills, HMO bills, before the Congress, ranging in scope from multibillion dollar support down to what Congress finally adopted, so that there were a variety of bills which the Congress itself then had rejected in this debate. I just want to mention again that throughout the debate the association called for support of this HMO experimental program.

Senator KENNEDY. Continue.

Dr. BEDDINGFIELD. Selective membership in HMO's is contrary to the previous intent of Congress in the passage of the present act and would defeat one basic purpose of the act. One of the essential reasons given for the necessity of passage of the HMO Act was to provide health care to those who ostensibly were unable to obtain such care. Should open enrollment be eliminated in conjunction with experience rating and in conjunction with the deletion of certain assistance being conditioned on serving medically underserved populations, then the very population which was used as proving the need for the HMO would be systematically eliminated from participation in the HMO. These people are the high utilizers of health care, including the elderly, the disabled, the poverty stricken. Are these individuals, for whom the HMO was created, now expected to rely upon a health care delivery system which the Congress apparently deemed to be inadequate?

Fifth, the amendments would remove the requirement that a medical group be primarily engaged in providing service to an HMO and would also include provisions for the entity to contract with individual health care professionals. Such provisions would seem to go counter to earlier arguments pointing out the working advantages to a health care professional and the assurance of continuity to the members of the entity. The original concept contemplated that major advantages would arise from the interest in keeping the individual well. The amendments would seem to invite paper organizations, which might rely on part-time, widely separated, and uncoordinated health professional efforts. Amendments adopted providing such contractual relationships between the entity and the health professional go far in changing the entity from the one-stop health center which proponents touted as the keystone of the HMO.

Further amendments of S. 1926 would delete the requirements that loan guarantees be made only to those entities in medically underserved areas, change the employee HMO option selection for only those areas in which at least 25 employees reside within the HMO

area, and extend funding for HMO's through fiscal 1979. In our view emphasis on the medically underserved areas should be maintained, as should dual option provisions which carry forward the intent of the original law, namely, to allow the employee himself the final choice of the type of health benefits plan under which he and his family would be covered.

Mr. Chairman, we have discussed the amendments in some detail. Viewing their effect as a whole, certain additional observations are warranted.

It is argued that the HMO Act was originally passed to create the conditions necessary to determine whether health maintenance organizations would meet with consumer and provider approval. In short, the HMO Act was enacted to create demonstration projects to ascertain whether the HMO concept, the organization which was to provide comprehensive, complete, prepaid care on a continuous and readily accessible basis for its members, could in fact be viable.

Perhaps now is the appropriate time to raise the question again as to what exactly is an HMO? Is an HMO an entity which will have various levels of care depending on where it is located, on its population, or on its level of premiums? Will an HMO change every year with a new congressional amendment? Is an HMO truly a health maintenance organization providing a comprehensive level of care as originally enunciated by Congress, or is it indeed merely a prepaid entity which progressively lowers its services to a point at which a maximum number of people will buy in? How exactly would an HMO differ from other prepaid group practices which indeed have been in existence for some 40 years? If in fact the HMO is to be no different from prepaid groups which have existed without Federal funding, then we submit there is no justification for Federal funding under the guise of experimentation or otherwise.

We submit, however, the public has been led to believe that an HMO is more than what has previously existed, is new, and is to mean what its name signifies, a health maintenance organization. Because of the present act, and all the discussion surrounding enactment, the public has come to expect that the care available to members of the HMO will include all necessary health care.

However, as we have pointed out, the amendments would remove important comprehensive services and eliminate characteristics which distinguish the HMO from other prepaid group practices.

It appears to us that the result of enacting the proposed amendments would be to convert a demonstration health delivery program into a mechanism for the funding of ordinary prepaid groups. Because this result would be so far beyond the initial intent of the original act, fairness requires that the act would have to be amended to delete the phrase "Health Maintenance Organization." This is especially necessary, for example, when one considers the indoctrination of vast numbers of employers and employees, who have by virtue of section 1310, been apprised that an HMO is a desirable, viable, comprehensive care organization. It would indeed be incongruous for us to continue calling something an HMO, in the sense that Congress intended it originally, while funding in reality an organization delivering substantially less than what was originally promised.

If the Congress adopts the presently proposed amendments, we believe that it would in effect have abandoned the "HMO concept" as originally intended and as now generally understood by the public. In addition, adoption of the amendments would be a decision now by the Congress that the HMO concept is not viable. An extensive change as contemplated would make invalid any later comparison of the new entities with the original HMO, and there could be no evaluation of the original HMO.

Mr. Chairman, before closing. I want to make it perfectly clear that our association is in strong support of a pluralistic health care delivery system.

Senator KENNEDY. Do you think we have one?

Dr. BEDDINGFIELD. A pluralistic system?

Senator KENNEDY. Yes.

Dr. BEDDINGFIELD. Yes; I think we have it.

Senator KENNEDY. What is your basis for that?

Dr. BEDDINGFIELD. Because of the elements that go into pluralism. We have the private sector, we have the physicians in solo practice, partnership practice, group practice, single specialty group practice, multispecialty group practice, prepaid groups existing, people going to the other entities I named a while ago, health department, hospital outpatient department, the efforts of the Government already existing in the veterans' hospital system. I think if anything is pluralistic, this is pluralistic.

Senator KENNEDY. Has it been the AMA's position to support prepaid group practice, and the establishment of the various group practices? Has that been the record of the AMA in developing pluralism?

Dr. BEDDINGFIELD. I believe the record will show that many, many years ago, two to three decades ago, the concept of prepaid group practice was not admittedly warmly received by the American Medical Association.

Senator KENNEDY. When did it change?

Dr. BEDDINGFIELD. I would estimate active opposition to this ceased probably some 20 years ago. I could give you more accurate information in a documentary presentation following the meeting if you would like this. We have many members who are respected members of AMA who do in fact practice with prepaid group practices at the same time.

Senator KENNEDY. All right. Proceed.

Dr. BEDDINGFIELD. Moreover, the hearings leading up to enactment of Public Law 93-222 will show our continued support for an experimental HMO program.

We must, however, question whether passage of these amendments under the guise of perfecting amendments to the Health Maintenance Organization Act is in the best interest of the public. In our opinion, the public deserves an answer as to whether the HMO, conceived after extended debate and promising accessible comprehensive care in a manner superior to other modes of health care delivery, is a viable concept. We believe the present experiment should proceed under the present act without adoption of the major changes proposed, and accordingly, neither S. 1926 nor H.R. 9019 should be adopted.

Mr. Chairman, we will be pleased to respond to any further questions which the committee may have.

Senator KENNEDY. I do not have any further questions. We want to thank you for your appearance here and your presentation. Thank you very much.

Dr. BEDDINGFIELD. Thank you very much for allowing us to appear.

Senator KENNEDY. Our last witness today is Dr. Daniel Patterson, chief, department of psychiatry, Group Health Association of Washington, D.C. Please proceed.

STATEMENT OF DANIEL PATTERSON, M.D., CHIEF, DEPARTMENT OF PSYCHIATRY, GROUP HEALTH ASSOCIATION OF WASHINGTON, D.C., ACCOMPANIED BY C. A. GIOLITO, DIRECTOR, GOVERNMENT RELATIONS, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. PATTERSON. Thank you, Mr. Chairman. It is a privilege to be here today to discuss pending HMO, health maintenance organization, amendments of 1975.

I had the honor of being the first Director of HEW's Health Maintenance Organization Service in 1971 before leaving to become chief of psychiatry of Group Health Association of Washington, a 100,000-member health maintenance organization, and I will add developed without Federal subsidy.

Today I am speaking in behalf of the American Psychiatric Association which represents 23,000 psychiatrists in the United States. With me is Mr. C. A. Giolito, director of Government relations of the American Psychiatric Association.

Before starting, I would want to alert you, Mr. Chairman, to some changes—last minute changes—in the printed testimony.

The American Psychiatric Association is supportive of the health maintenance organization concept and believes that the health maintenance organization should be a part of the present pluralistic health system. The association has been favorably impressed by studies of the quality of health services provided by HMO's and by their ability to do so cost effectively.

It has been our contention that in a pluralistic competitive market, the HMO should not be unduly subsidized or unfairly advantaged through legislative action. On the other hand, we agree that the HMO should also not be unfairly burdened or competitively disadvantaged.

In our opinion, the HMO Act of 1973 may have made some unrealistic expectations of emerging HMO's, which may have placed them at competitive disadvantage. S. 1926, as we understand it, is intended to rectify these possible errors and to facilitate the development of HMO's, and allow them to compete in a fair market test with private health insurers.

The American Psychiatric Association unequivocally believes that a reasonable level of inpatient mental health services must be a part of the basic benefit package. Noninclusion of this benefit would be the one glaring omission in what properly constitutes a basic benefit package for delivery of comprehensive services.

We are asking therefore that inpatient mental health services be made a part of basic health services.

On the surface, this request appears to contradict the stated intent of S. 1926. We do not believe, however, that the provision of these

services would impact negatively on the stated intent of S. 1926 for these reasons:

First, the private insurance market already requires that health insurers provide inpatient mental health benefits. By the end of 1970, 63 percent of the U.S. civilian population (128 million persons) had some coverage of hospital care for mental conditions under private health insurance.

We respectfully submit for the record a study recently completed by the American Psychiatric Association, entitled "Coverage and Utilization of Care for Mental Conditions Under Health Insurance"—various studies, 1973-74, which we feel support this more substantively.

Senator KENNEDY. You can submit them, and we will include them in the record.

**COVERAGE AND UTILIZATION OF CARE FOR MENTAL CONDITIONS
UNDER HEALTH INSURANCE—VARIOUS STUDIES, 1973-1974**

LOUIS S. REED, Ph.D.
Consultant in Health Economics
American Psychiatric Association

This publication may be ordered at \$4.00 per copy from the American Psychiatric Association, 1700 18th Street, N.W., Washington, D.C. 20009. There is a 10% discount for 10 copies or more and 20% for 50 or more.

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FOREWORD

This volume in one sense may be considered as a supplement to the book, *Health Insurance and Psychiatric Care: Utilization and Cost*, by Reed, Myers, and Scheidemandel, published by the American Psychiatric Association in 1972. In a larger context it is the most recent of a series of efforts by the American Psychiatric Association to make pertinent information available to psychiatrists, other physicians and mental health professionals, the general public, insurance organizations, and government officials, in order to facilitate better coverage of mental conditions under health insurance and ultimately to achieve the same coverage of care for mental and emotional illness as of all other illness. We may assume that this issue will continue to be discussed intensively as part of health policy decisions during the next decade and beyond. The American Psychiatric Association will be an active participant in these discussions and it is highly likely that we will sponsor additional publications on the subject in the future.

There are indications that our efforts along this line, and particularly the 1972 report, have been bearing fruit. We believe there has been a general tendency towards liberalization of mental illness coverage under insurance. Several states have passed laws requiring at least minimum coverage of mental disorders under new private health insurance contracts. The bills for national health insurance that have been introduced in Congress during the last two years have for the most part provided better coverage of mental disorders than the earlier ones. We are more optimistic about the coverage that will be provided under national health insurance when some program is finally enacted than we were four or five years ago.

The present volume largely results from a contract which APA entered into in the spring of 1974 with the National Institute of Mental Health (which had financed the earlier study) to undertake a study to update information concerning insurance coverage and utilization, the work to be performed by Dr. Louis S. Reed, who had directed the earlier study. The contract provided that studies were to be performed in five areas which NIMH and APA considered especially important. These were:

1. A comparison of benefits for mental and other conditions under selected employee health benefit plans on which information was published by the U.S. Department of Labor.
2. Development of up-to-date information on utilization of care for mental conditions under the Canadian hospital and medical insurance programs. Since these programs provide full coverage of care for mental conditions, it was felt that utilization data would be especially significant.
3. Information on the coverage of care for mental conditions under the collective bargaining agreements of selected unions.
4. Information on Blue Cross benefits for hospital care of mental illness, updating the information for 1971 published in the earlier report.
5. A survey of selected Blue Cross and Blue Shield plans to obtain data on coverage and utilization of care for mental conditions, with emphasis on outpatient care.

These studies were conducted and a report was submitted to NIMH. Since that organization was unable to finance publication of the studies, it gave APA permission to publish them.

The lead study in this volume—that relating to utilization experience under the Blue Cross and Blue Shield Plan for Federal Employees—was not done under the NIMH contract but was a separate undertaking of APA. The utilization experience under this program, covering over 5,000,000 persons nationwide, with relatively comprehensive benefits and virtually the same coverage of mental as of other conditions, undoubtedly constitutes the best single source of data on the utilization and cost of care for mental conditions under health insurance. Accordingly, we requested Dr. Reed to analyze the utilization experience in 1972, 1973, and 1974, and to make a detailed study of certain aspects of utilization in 1973; special data were available for the latter year because of requests made to the plan by the Civil Service Commission.

Each of the six studies in this publication is a discrete entity; no effort has been made to fit them into a coherent package. Nor has any effort been made to put the information into an historical context; for such a context the reader is referred to Chapter 1 of *Health Insurance and Psychiatric Care: Utilization and Cost*.

I do not believe it is necessary here to summarize the findings in Dr. Reed's six studies. However, I would like to single out for brief mention two of the findings that I think are particularly noteworthy.

The upward trend in utilization of benefits for mental disorders that had characterized the high option of the Blue Cross and Blue Shield Plan for Federal Employees since its beginning in 1960 appears to have ended. Utilization leveled off in 1973 and 1974. Thus in 1972 benefits for mental disorders constituted 7.3 percent of benefits for all conditions; in 1973 they constituted 7.4 percent; and in 1974 they were back down to 7.3 percent.

An examination of a rough cross-section of employee health benefit plans in American industry (including many of the major corporations such as IBM, General Motors, and U.S. Steel) reveals that almost all of the plans have some coverage of hospital care for mental conditions and that about two thirds have the same hospital coverage for mental as for other conditions when the care is given in general hospitals. Also, about nine out of ten of the plans have some coverage of office care for general and/or mental conditions; nearly half of these have the same coverage for mental as for other conditions. Most of the rest have reduced outpatient benefits for mental conditions, but six percent—mainly plans negotiated by the United Auto Workers—have greater outpatient benefits for mental than for other conditions.

Dr. Reed desires to make several acknowledgements. Mr. Charles K. Kanno assisted in the statistical analyses for the Blue Cross and Blue Shield federal employees study; he and Mrs. Patricia L. Scheideman edited the report and readied it for publication. Mrs. Evelyn S. Myers, managing editor of *The American Journal of Psychiatry*, gave helpful counsel at various stages of the work. I should like to add my commendation to Dr. Reed and the other staff members for a job well done.

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STUDY 1

UTILIZATION OF CARE FOR MENTAL DISORDERS UNDER THE BLUE CROSS AND BLUE SHIELD PLAN FOR FEDERAL EMPLOYEES

OVERALL UTILIZATION EXPERIENCE, 1974

The utilization of care for mental conditions under the Blue Cross and Blue Shield Plan for Federal Employees is of special interest because the plan, in comparison with most other employee health benefit programs, a) provides relatively comprehensive benefits with virtually the same coverage of mental as of other conditions, b) covers a large population that is somewhat representative of the general population,¹ and c) develops excellent, detailed utilization statistics. The experience in 1974 is noteworthy because then, as in 1973, utilization of benefits for mental conditions as a percent of those for all conditions did not increase but stayed at the same level as in 1972.

The plan covered an average of 5,587,900 persons during 1974—4,887,700 under the high option and 700,200 under the low option.

Benefits provided under the program were the same in 1974 as in 1973 and 1972 except for certain minor changes which, on the whole, increased benefits. Benefits under both options consist of basic hospital benefits, basic surgical-medical-maternity benefits, and supplemental benefits. Under the high option, basic hospital benefits included complete inpatient care in semiprivate accommodations for up to 365 days for each confinement. An admission within 60 days of discharge from a previous confinement was considered as an extension of that confinement; after 60 days it was considered a new confinement (the period was 90 days in 1973). The same benefits were provided for mental conditions, but only in general hospitals and in the mental hospitals that were member hospitals of Blue Cross plans. Care in nonmember mental hospitals was covered under supplemental benefits, while care in nonmember general hospitals was paid for at 80 percent of the charges, with the balance covered under supplemental benefits. Outpatient benefits were the same for mental disorders as for other conditions. Basic surgical-medical-maternity benefits included surgical and anesthesia services wherever performed, in-

hospital medical care, maternity care, including prenatal and postnatal care, and X-ray and laboratory services in or out of hospital. In all areas of the country except three (Rochester and Jamestown, New York, and Connecticut), physicians were paid in 1974 on the basis of their usual, customary, and reasonable charges for their services so that virtually all reasonable charges were paid in full. Supplemental benefits paid 80 percent of covered charges in excess of a deductible of \$100 per person per year, up to maximum benefits of \$250,000 (\$50,000 in 1973) for hospital and physicians' services not covered under basic benefits, and for prescribed drugs, private-duty nursing service, appliances, rental of durable medical equipment, and certain other items. The same benefits were provided for mental disorders as for other conditions.

Under the low option, basic hospital benefits were limited to 90 days per confinement, basic surgical-medical benefits consisted of scheduled indemnities or allowances against physicians' charges, and supplemental benefits paid only 75 percent of covered charges in excess of a deductible of \$150 per person per year, up to maximum benefits of \$150,000 (\$25,000 in 1973).

Utilization

Tables 1-4 show utilization in 1974 under the high option, Tables 5-8 utilization under the low option.²

Under the high option in 1974, there were 5.0 inpatient admissions under basic hospital benefits for mental disorders per 1,000 covered population, equal to 3.8 percent of admissions for all conditions (Table 1). The average length of stay was 17.1 days compared with 7.3 days for all conditions. Total days of care for mental conditions numbered 86.3 per 1,000 population, equal to 8.9 percent of the days provided for all conditions. The charge per day for mental admissions averaged \$75.34, compared with \$108.29 for all conditions. Total inpatient covered charges—in effect, benefits paid—for mental disorders amounted to \$6.50 per person covered.

¹However, the federal employee population covered by this plan probably has a higher proportion of white-collar workers, a higher average income, and a higher level of education than the general working population. Approximately 21 percent of the covered population live in the District of Columbia, Maryland, and Virginia.

²These tables were developed from data contained in the plan's 1974 *Annual Utilization Report* submitted to the U.S. Civil Service Commission, with certain detailed data on surgical-medical basic benefits for mental conditions obtained directly from the plan. All data are for claims paid during 1974.

TABLE 1
Utilization of Basic Hospital Benefits, High Option, 1974

	Inpatient						Outpatient		
	Number of admissions	Number of days	Average length of stay (days)	Covered charges (benefits)	Charges per day	Charges per admission	Admissions	Covered charges	Charges per admission
All conditions									
Nonmaternity	584,429	4,486,721	7.7	\$476,101,557	\$106.11	\$814.64	1,284,274	\$40,773,186	\$31.75
Maternity	63,686	229,402	3.6	34,593,802	150.80	543.19	—	—	—
Total	648,115	4,716,123	7.3	510,695,359	108.29	787.97	1,284,274	40,773,186	31.75
Per 1,000 covered population	132.9	966.9	—	—	—	—	263.3	—	—
Per person covered	—	—	—	104.70	—	—	—	8.36	—
Mental disorders	24,598	421,141	17.1	31,728,844	75.34	1,289.90	3,249	86,988	26.77
Per 1,000 covered population	5.0	86.3	—	—	—	—	0.7	—	—
Per person covered	—	—	—	6.50	—	—	—	.02	—
Mental disorders as percent of all conditions	3.8%	8.9%	—	6.2%	—	—	0.3%	0.2%	—
Covered population (average for 1974) —	4,877,700								

equal to 6.2 percent of covered charges paid per covered person for all conditions. Outpatient admissions and covered charges for mental disorders were minuscule compared with those for all conditions—0.3 percent of all admissions and 0.2 percent of covered charges.

Under high option basic surgical-medical benefits, there were 5.9 claims per 1,000 covered population for mental disorders, of which 0.4 were for electroshock therapy, 0.3 for anesthesia, 2.9 for psychotherapy, and 2.3 for other medical care (Table 2). Total claims were 1.7 percent of those for all conditions. Visit days for mental disorders numbered 65.8 per 1,000 covered population, equal to 10.4 percent of visit days for medical care for all conditions. Visit days for psychotherapy were 38.1 per 1,000 population, those for other medical care, 26.6. Total benefits paid for mental disorders amounted to \$1.45 per person covered, equal to 3.6 percent of benefits for all conditions. Claims and benefits paid for hospital outpatient services for mental disorders were very small—claims were 0.02 percent of total claims and benefits were 0.1 percent of total benefits. All were for electroshock therapy and anesthesia in connection therewith. Benefits per person covered amounted to 2 cents.

Under supplemental benefits, the number of cases (i.e., claims) for reimbursement of hospital charges for care of mental disorders (this would be for care in nonmember mental hospitals) was 1.2 per 1,000 population; covered charges (payable at 80 percent after the deductible of \$100) came to \$1.28 per covered person (Table 3). Both claims and covered charges were down from 1973, indicating less utilization of nonmember mental hospitals. Mental disorder claims were 18.3 percent of all supplemental hospital claims and mental disorder charges were 65.2 percent of those for all

conditions; the proportion is high because almost all care for general conditions is paid for under basic benefits. (It would be useful to know what proportion of admissions, days, and covered charges for mental conditions under basic hospital benefits were in general hospitals and what proportion were in member mental hospitals. Unfortunately, these data are not available.)

Claims for reimbursement of physicians' charges for care of mental disorders under supplemental benefits numbered 20.8 per 1,000 population, equal to 18.7 percent of those for all conditions. (Since physicians' usual, customary, and reasonable charges for inpatient care are paid in full under basic benefits, all would be for outpatient care.) Total charges for covered services under these claims (i.e., before application of the deductible and coinsurance) amounted to \$5.10 per covered person, equal to 46.4 percent of physicians' charges for all conditions under supplemental benefits. Estimated benefits paid for physicians' services for mental disorders under supplemental benefits were \$3.75 per covered person, equal to 53.4 percent of benefits paid for physicians' services for all conditions under supplemental benefits. The high proportion of covered charges and benefits for mental conditions is due to a number of factors: a) a large proportion of all psychiatric care is rendered in the physician's office; b) much outpatient care of other physicians—all surgery, all X-ray and laboratory services—is covered under basic benefits; c) a few visits to a psychiatrist will result in charges exceeding the deductible so that a claim will be filed, whereas in the case of other conditions many persons will have only a few visits to doctors during the year and the charges for such visits will not aggregate more than \$100, so that no benefits are payable. Benefits paid for physicians' services, inpatient and outpatient, for all

TABLE 2
Utilization of Basic Surgical-Medical Benefits, High Option, 1974

Type of service	Claims			Visit days		Inpatient				Outpatient			
	Number	Per 1,000	Number	Per 1,000	Amount of benefits	Benefits per claim	Benefits per person covered	Number of claims	Amount of benefits	Benefits per claim	Benefits per person covered		
All conditions													
Nonmaternity													
Surgery	439,191	90.0	—	—	\$98,084,329	\$223.33	\$20.11	1,166,745	\$37,254,482	\$31.93			
Anesthesia	221,037	45.3	—	—	18,331,621	82.93	3.76	9,363	457,773	48.89			
Medical care	492,174	100.9	3,089,403	633.4	41,534,037	84.39	8.52	464,386	9,038,966	19.46			
Diagnostic													
X ray	88,386	18.1	—	—	4,411,035	49.91	.90	971,002	26,131,737	26.91			
Dental care	11	—	—	—	251	22.82	^a	586	10,632	18.14			
Consultation	105,021	21.5	—	—	3,664,598	34.89	.75	—	—	—			
Other	274,104	56.2	—	—	11,255,941	41.06	2.31	1,914,586	29,535,780	15.43			
Total	1,619,924	332.1	—	—	177,281,813	109.44	36.35	4,526,668	102,429,370	22.63			
Maternity	86,985	17.8	—	—	18,444,971	212.05	3.78	—	—	—			
Total	1,706,909	349.9	3,089,403	633.4	195,726,784	114.67	40.13	4,526,668	102,429,370	22.63			
Mental disorders													
Electroshock therapy	28,887	5.9	321,068	65.8	7,049,806	244.05	1.45	958	85,063	88.79			
Anesthesia	2,126	4	5,582	1.1	435,347	204.77	.09	771	79,382	102.96			
Psychotherapy	1,337	3	58	—	68,397	51.16	.01	187	5,681	30.38			
Other medical care	13,964	2.9	185,641	38.1	3,970,192	284.32	.81	—	—	—			
Total	11,460	2.3	129,787	26.6	2,575,870	224.77	.53	—	—	—			
Mental disorders (total) as percent of total for all conditions	1.7%	—	10.4%	—	3.6%	—	—	.02%	.1%	—			

^a Less than \$.01.

^aLess than \$.01.

TABLE 3
Utilization of Supplemental Benefits, High Option, 1974

Type of service	Cases		Charges for covered services			Benefits per person covered
	Number	Per 1,000 population	Amount	Per person covered	Per case	
All conditions						
Hospital	32,551	6.7	\$9,566,830	\$1.96	\$293.90	\$1.25 ^b
Physician	544,078	111.5	53,678,264	11.00	98.66	7.02 ^b
Special nursing	6,052	1.2	2,450,754	.50	404.95	.32 ^b
Drugs	445,401	91.3	38,082,593	7.81	85.50	4.98 ^b
Other	64,989	13.3	9,179,851	1.88	141.25	1.20 ^b
Total	1,093,071	224.1	\$112,958,292	\$23.16	\$103.34	\$14.77
Covered by program	—	—	72,024,753 ^a	14.77	—	14.77
Patient paid	—	—	40,904,164 ^a	8.39	—	—
Percent covered by program	—	—	63.8%	—	—	—
Mental disorders						
Hospital	5,955	1.2	6,235,355	1.28	1,047.08	.94 ^b
Physician	101,515	20.8	24,886,957	5.10	245.16	3.75 ^b
Special nursing	369	.1	55,755	.01	151.10	.01 ^b
Drugs	31,594	6.5	2,270,049	.47	71.85	.35 ^b
Other	18,643 ^c	3.8	4,707,086 ^c	.97	252.49	.71 ^b
Total	158,076	32.4	38,155,202	7.82	241.37	5.76
Covered by program	—	—	28,079,446 ^a	5.76	—	5.76
Patient paid	—	—	10,069,716 ^a	2.06	—	—
Percent covered by program	—	—	73.6%	—	—	—
Mental disorders as percent of total						
Hospital	18.3%	—	65.2%	—	—	75.2%
Physician	18.7	—	46.4	—	—	53.4
Special nursing	6.1	—	2.3	—	—	3.1
Drugs	7.1	—	6.0	—	—	7.0
Other	28.7	—	51.3	—	—	59.2
Total	14.5	—	33.8	—	—	39.0 ¹

^aDoes not add to total because of rounding at various steps.

^bEstimated by applying percent covered by program for all charges.

^cIncludes charges of psychologists.

conditions under basic and supplemental benefits amounted to approximately \$48.15 per covered person, for mental conditions \$5.22, or 11 percent.

Claims for reimbursement of special nursing charges were negligible; drug claims were 6.5 per 1,000 population with covered charges of 47 cents per person. Claims for reimbursement of other charges—including those of psychologists—numbered 3.8 per 1,000 population and charges for covered services amounted to 97 cents per covered person. (In 1974 the plan paid psychologists' charges only when the services were performed at the direction and under the supervision of the attending physician. As of January 1, 1975, this requirement was eliminated.) Total benefits paid under supplemental benefits for mental disorders amounted to \$5.76 per covered person, equal to 39 percent of those for all conditions. Total benefits paid for mental disorders for all types of care amounted to \$13.74 per covered person, equal to 7.3 percent of benefits (\$188.95) paid for all conditions (Table 4).

Utilization under the low option (Tables 5-8) was much lower than under the high option. This is due to some extent to the more restricted benefits, but more important is the fact that the population covered by the low option is, on the average, younger and healthier than

the high-option population. It apparently includes many persons who selected a low-cost plan because they thought they were healthy and were aware of no health conditions for which they might require medical care. By contrast, persons receiving psychiatric care or aware that they might need such care would certainly shift to the high option if they were not already enrolled in it.

TRENDS IN UTILIZATION, 1966-1974

Utilization of care for mental disorders under the high option was virtually the same in 1974 as in 1973 and 1972 (Table 9). The upward trend in utilization of benefits for mental disorders which had characterized the plan virtually since its beginning in 1960 appeared to have ended and leveled out in 1973 and 1974.³ In 1974 benefits

³Data in Tables 9 and 10 for 1972 and earlier years are from L. S. Reed, E. S. Myers, and P. I. Scheidemandel: *Health Insurance and Psychiatric Care: Utilization and Cost*, American Psychiatric Association, 1972, and from L. S. Reed: "Utilization of Care for Mental Disorders Under the Blue Cross and Blue Shield Plan for Federal Employees, 1972," *American Journal of Psychiatry*, September 1974. Data for 1973 are from an unpublished study performed by the author for the American Psychiatric Association.

TABLE 4
Summary of Benefits Paid, High Option, 1974

Type of benefits	Covered charges or benefits paid				
	All conditions		Mental disorders		Mental disorders as percent of all conditions
	Amount	Per person covered	Amount	Per person covered	
Basic hospital benefits					
Inpatient	\$510,695,359	\$104.70	\$31,728,844	\$6.50	6.2%
Outpatient	40,773,186	8.36	86,988	.02	0.2
Total	\$551,468,545	\$113.06	\$31,815,832	\$6.52	5.8
Basic surgical-medical benefits					
Inpatient	\$195,726,784	\$40.13	\$7,049,806	\$1.45	3.6
Outpatient	102,429,370	21.00	85,063	.02	.1
Total	298,156,155	61.13	7,134,869	1.46	2.4
Supplemental benefits	\$72,024,753	\$14.77	\$28,079,446	\$5.76	39.0%
Total all benefits	\$921,649,453	\$188.95	\$67,030,147	\$13.74	7.3%

for mental disorders constituted 7.3 percent of benefits for all conditions, as compared with 7.4 percent in 1973 and 7.3 percent in 1972. Basic hospital benefits for mental disorders were 5.8 percent of benefits for all conditions in 1974, the same as in 1973 and less than the 5.9 percent in 1972. Basic surgical-medical benefits for mental disorders were 2.4 percent of benefits for all conditions in 1974 and in 1973, and 2.3 percent in 1972. Supplemental benefits for mental disorders were 39.0 percent of those for all conditions, compared with 38.4 percent in 1973 and 38.7 percent in 1972.

Under the low option, however, the percentage of total benefits paid for mental conditions continued its upward trend. Total benefits for mental disorders constituted 5.5 percent of those for all conditions, as compared with 5.2 percent in 1973, 4.6 percent in 1972, and 4.4 percent in 1969.

Looking in more detail at trends in utilization under the high option (Table 10), it will be seen that the hospital admission rate under basic benefits for mental disorders—5.0 per 1,000 covered population—was slightly higher than in 1973 but lower than in 1972. The proportion of admissions for mental disorders to all admissions has stayed about the same. The average length of stay for mental conditions—17.1 days—was lower in 1974 than in 1973 and 1972, and days per 1,000 were lower in 1974 than in 1973 and 1972. In-hospital visit days for mental disorders per 1,000 population were higher than in 1973 but lower than in 1972.

Under supplemental benefits, hospital cases (claims) for mental disorders numbered 1.2 per 1,000 population, slightly lower than in 1973 and 1972. The proportion of such cases to the total—18.3 percent—was markedly off from its peak—24.3 percent—in 1972. Hospital charges

TABLE 5
Utilization of Basic Hospital Benefits, Low Option, 1974

	Inpatient						Outpatient		
	Number of admissions	Number of days	Average length of stay (days)	Covered charges (benefits)	Charges per day	Charges per admission	Admissions	Covered charges	Charges per admission
All conditions									
Nonmaternity	59,637	438,967	7.4	\$34,234,129	\$77.99	\$574.04	113,243	\$3,241,746	\$28.63
Maternity	4,716	14,795	3.1	1,410,683	95.35	299.13	—	—	—
Total	64,353	453,762	7.1	35,644,812	78.55	553.90	113,243	3,241,746	28.63
Per 1,000 covered population	91.9	648.0	—	—	—	—	161.7	—	—
Per person covered	—	—	—	50.91	—	—	—	4.63	—
Mental disorders	1,952	27,068	13.9	1,872,428	69.17	959.24	265	6,851	25.95
Per 1,000 covered population	2.8	38.7	—	—	—	—	0.4	—	—
Per person covered	—	—	—	2.67	—	—	—	.01	—
Mental disorders as percent of all conditions	3.0%	6.0%	—	5.3%	—	—	0.2%	0.2%	—
Covered population (average for 1974)	— 700,200								

TABLE 6
Utilization of Basic Surgical-Medical Benefits, Low Option, 1957

Type of service	Claims			Inpatient			Outpatient						
	Number	Per 1,000	Visit days	Number	Per 1,000	Benefits per person covered	Benefits per claim	Amount of benefits	Benefits per person covered	Number of claims	Amount of benefits	Benefits per claim	Benefits per person covered
All conditions													
Nonmaternity													
Surgery	42,216	60.3	—	—	—	\$5.53	\$91.73	\$3,872,560		91,258	\$1,761,258	\$19.30	\$2.52
Anesthesia	19,333	27.6	—	—	—	.80	28.90	558,655		664	14,551	21.91	.02
Medical care	44,010	62.9	275,692	393.7	*	2.14	34.12	1,501,743		32,974	458,511	13.91	.65
Diagnostic													
X ray	5,101	7.3	—	—	—	.28	38.84	198,129		73,863	1,491,111	20.19	2.13
Dental care	1	—	—	—	—	a	25.00	25		62	1,027	16.57	—
Consultation	8,488	12.1	—	—	—	.21	17.09	145,076		—	—	—	—
Other	20,169	28.8	—	—	—	.86	29.72	599,503		128,980	1,647,216	12.77	2.35
Total	139,318	199.0	—	—	—	9.82	49.35	6,875,691		327,801	5,373,674	16.39	7.67
Maternity	5,283	8.3	—	—	—	.88	106.90	618,184		—	—	—	—
Total	145,101	207.2	275,692	393.7		10.70	51.65	7,493,875		327,801	5,373,674	16.39	7.67
Mental disorders	1,762	2.5	17,601	25.1		.27	108.04	190,359		43	2,002	46.56	a
Electroshock therapy	104	.1	277	.4		.02	124.23	12,920		31	1,885	60.79	a
Anesthesia	86	.1	—	—		a	19.50	1,677		12	118	9.79	a
Psychotherapy	877	1.3	10,537	15.0		.16	131.04	114,924		—	—	—	—
Other medical care	695	1.0	6,787	9.7		.09	87.54	60,838		—	—	—	—
Mental disorders (total) as percent of total for all conditions	1.2%	—	6.4%	—		—	—	2.5%		.01%	.04%	—	—

a Less than \$0.1.

a Less than \$01.

TABLE 7
Utilization of Supplemental Benefits, Low Option, 1974

Type of service	Cases		Charges for covered services			Benefits per person covered
	Number	Per 1,000 population	Amount	Per person covered	Per case	
All conditions						
Hospital	3,203	4.6	\$918,146	\$1.31	\$286.65	\$.86 ^c
Physician	50,836	72.6	4,495,597	6.42	88.43	4.19 ^c
Special nursing	393	.6	122,124	.17	310.75	.11 ^c
Drugs	47,428	67.7	2,796,914	3.99	58.97	2.61 ^c
Other	4,944	7.1	445,256	.64	90.06	.41 ^c
Total	106,804	152.5	\$8,778,037	\$12.54	\$82.19	\$8.18
Covered by program	—	—	5,728,497 ^a	8.18	—	8.18
Patient paid	—	—	3,049,205 ^a	4.35	—	—
Percent covered by program	—	—	65.3%	—	—	—
Mental disorders						
Hospital	482	.7	475,825	.68	987.19	.45 ^c
Physician	4,176	6.0	932,732	1.33	223.36	.87 ^c
Special nursing	11	—	777	^b	70.64	^b
Drugs	1,467	2.1	92,776	.13	63.24	.09 ^c
Other	793 ^d	1.1	175,977 ^d	.25	221.91	.16 ^c
Total	6,929	9.9	1,678,087	2.40	242.18	1.58
Covered by program	—	—	1,103,176 ^a	1.58	—	1.58
Patient paid	—	—	575,521 ^a	.82	—	—
Percent covered by program	—	—	65.7%	—	—	—
Mental disorders as percent of total						
Hospital	15.0%	—	51.8%	—	—	52.3%
Physician	8.2	—	20.7	—	—	20.8
Special nursing	2.8	—	0.6	—	—	0.6
Drugs	3.1	—	3.3	—	—	3.4
Other	16.0	—	39.5	—	—	39.0
Total	6.5	—	19.1	—	—	19.3

^aDoes not add to total because of rounding at various steps.

^bLess than \$.01.

^cEstimated by applying percent covered by program for all charges.

^dIncludes charges of psychologists.

TABLE 8
Summary of Benefits Paid, Low Option, 1974

Type of benefits	Covered charges or benefits paid				Mental disorders as percent of all conditions
	All conditions		Mental disorders		
	Amount	Per person covered	Amount	Per person covered	
Basic hospital benefits					
Inpatient	\$35,644,812	\$50.9 ¹	\$1,872,428	\$2.67	5.3%
Outpatient	3,241,746 ^a	4.53	6,851	.01	0.2
Total	\$38,886,558	\$55.52	\$1,879,279	\$2.68	4.8
Basic surgical-medical benefits					
Inpatient	\$7,493,875	\$10.70	\$190,359	\$.27	2.5
Outpatient	5,373,674	7.67	2,002	^a	.04
Total	\$12,867,549	\$18.38	\$192,361	.27	1.5
Supplemental benefits	\$5,728,497	\$8.18	\$1,103,176	\$1.58	19.3
Total all benefits	\$57,482,604	\$82.09	\$3,174,816	\$4.53	5.5%

^aLess than \$.01.

TABLE 9
Changes in Utilization, All Benefits, 1966-1974

Item	Utilization				
	1966	1969	1972	1973	1974
<i>High option</i>					
Basic hospital benefits per covered person					
All conditions	\$45.08	\$67.30	\$97.25	\$102.70	\$113.06
Mental disorders	1.80	3.24	5.70	5.97	6.52
Mental disorders as percent of all conditions	4.0%	4.8%	5.9%	5.8%	5.8%
Basic surgical-medical benefits per covered person					
All conditions	19.03	32.54	51.96	54.03	61.13
Mental disorders	.29	.66	1.19	1.28	1.46
Mental disorders as percent of all conditions	1.5%	2.0%	2.3%	2.4%	2.4%
Supplemental benefits per covered person					
All conditions	8.11	10.14	13.00	14.12	14.77
Mental disorders*	1.40	3.19	5.03	5.42	5.76
Mental disorders as percent of all conditions	17.3%	31.4%	38.7%	38.4%	39.0%
All benefits per covered person					
All conditions	72.22	109.98	162.21	170.85	188.95
Mental disorders	3.50	7.07	11.92	12.67	13.74
Mental disorders as percent of all conditions	4.8%	6.4%	7.3%	7.4%	7.3%
<i>Low option</i>					
Basic hospital benefits per covered person					
All conditions	\$24.59	\$33.97	\$43.97	\$51.37	\$55.54
Mental disorders	.70	1.12	1.59	2.23	2.68
Mental disorders as percent of all conditions	2.8%	3.3%	3.6%	4.3%	4.8%
Basic surgical-medical benefits per covered person					
All conditions	8.22	11.75	15.05	16.64	18.38
Mental disorders	.08	.12	.15	.23	.27
Mental disorders as percent of all conditions	1.0%	1.0%	1.0%	1.4%	1.5%
Supplemental benefits per covered person					
All conditions	2.38	3.45	5.76	7.45	8.18
Mental disorders*	.46	.94	1.26	1.44	1.58
Mental disorders as percent of all conditions	19.2%	27.2%	21.8%	19.4%	19.3%
All benefits per covered person					
All conditions	35.19	49.17	64.78	75.47	82.09
Mental disorders	1.24	2.18	3.00	3.90	4.53
Mental disorders as percent of all conditions	3.5%	4.4%	4.6%	5.2%	5.5%

*In 1966, physician charges for outpatient care of mental disorders were reimbursed at only 50 percent, in contrast to 80 percent for all other conditions.

for mental disorders per person covered—\$1.28 in 1974—were lower than in 1973 and about the same as in 1972. Taken together with per person charges for hospital care for mental disorders under basic benefits, it is evident that most of the hospital care for mental disorders was given in general hospitals and member mental hospitals. Physicians' cases (claims) for care of mental disorders numbered 20.8 per 1,000 in 1974, compared with 19.0 in 1973 and 18.5 in 1972. Physicians' charges per covered person for care of mental disorders (to all intents and purposes this is for care in the office) amounted to \$5.10 per covered person in 1974, compared with \$4.77 in 1973 and \$4.72 in 1972. Such charges were 46.4 percent of physicians' charges for all conditions, as against 48.2 percent in 1973 and 47.9 percent in 1972.

In summary, utilization of care for mental disorders as a percentage of utilization of care for all conditions

under the high option reached a peak in 1972 and has since leveled off. This is true for both inpatient and outpatient care. Utilization under the low option has continued to increase and may well continue to increase until the level of utilization as a percentage of all conditions is closer to that under the high option.

UTILIZATION BY AGE AND SEX, 1973

In 1974 the U.S. Civil Service Commission directed the plan to make special computer runs of data under the high option plan in order to provide the raw material for detailed analyses of utilization of care for mental conditions. Printouts were made available to the American Psychiatric Association by the Civil Service Commission. From these printouts data were compiled under the

Changes in Utilization, High Option, Various Items, 1966-1974

Item	Utilization				
	1966	1969	1972	1973	1974
Basic hospital benefits					
Admission rate per 1,000 covered population					
All conditions	133.6	130.7	131.7	131.0	132.9
Mental disorders	3.7	4.3	5.1	4.9	5.0
Mental disorders as percent of all conditions	2.8%	3.3%	3.9%	3.8%	3.8%
Rate of days of care per 1,000 covered population					
All conditions	978.9	984.7	994.6	971.7	966.9
Mental disorders	58.9	69.8	89.2	86.9	86.3
Mental disorders as percent of all conditions	6.0%	7.1%	9.0%	8.9%	8.9%
Average length of stay (in days)					
All conditions	7.3	7.5	7.6	7.4	7.3
Mental disorders	15.8	16.3	17.6	17.6	17.1
Basic surgical-medical benefits					
In-hospital visit days per 1,000 covered population					
All conditions	587.9	591.3	657.6	632.7	633.4
Mental disorders	48.2	57.6	71.7	64.6	65.8
Mental disorders as percent of all conditions	8.2%	9.7%	10.9%	10.2%	10.4%
In-hospital visit-day benefits per visit day					
All conditions	\$6.12	\$8.43	\$10.96	\$12.24	\$13.44
Mental disorders	5.97	11.11	16.33	19.45	21.96
Supplemental benefits					
Hospital cases per 1,000 covered population					
All conditions	13.9	6.3	5.4	6.0	6.7
Mental disorders	1.6	1.3	1.3	1.3	1.2
Mental disorders as percent of all conditions	11.8%	21.2%	24.3%	21.5%	18.3%
Hospital charges per covered person					
All conditions	\$1.42	\$1.45	\$1.82	\$2.08	\$1.96
Mental disorders	.62	.90	1.26	1.35	1.28
Mental disorders as percent of all conditions	43.7%	62.3%	68.4%	65.0%	65.2%
Physician cases per 1,000 covered population					
All conditions	68.8	70.6	82.8	87.6	111.5
Mental disorders	8.3	13.3	18.5	19.0	20.8
Mental disorders as percent of all conditions	12.1%	18.8%	22.3%	21.7%	18.7%
Physician charges per covered person					
All conditions	\$7.09	\$8.12	\$9.85	\$9.90	\$11.00
Mental disorders	1.67	2.99	4.72	4.77	5.10
Mental disorders as percent of all conditions	23.6%	36.8%	47.9%	48.2%	46.4%

direction of the author to show *a*) utilization by age and sex and by region, *b*) hospital admissions by duration of stay and distribution of persons hospitalized by days of care during the year, and *c*) distribution of persons with physicians' charges for care of mental disorders under supplemental benefits by amount of charges.⁴ The resulting data are set forth in Tables 11 to 27 and are discussed in this and the following sections.

Unfortunately, the plan does not have data on the age and sex distribution of the covered population; it has such data only for enrolled employees and annuitants, *i.e.*, not their dependents. The Civil Service Commis-

sion's Office of the Actuary, using census data on family composition, made an estimate of the distribution of dependents by age and sex. It acknowledges this estimate to be rough and possibly faulty. The combined data on the distribution of the total covered population by age and sex, both at the end of 1973 and on the average during 1973, are set forth in Table 11.

Table 12 shows utilization by age and sex of inpatient hospital care for mental disorders under basic benefits, *i.e.*, in general hospitals and member mental hospitals. The admission rate was relatively very low—1.3 per 1,000—for children, increased more than six times to 8.3 in the age group 19-34, peaked in the 45-54 age group at 8.9, declined to 6.8 among ages 55-64, and declined still further to 3.8 among those 65 and over. The male rates for ages 19-34 and 35-44 are probably faulty due to a faulty estimate of the covered population—the rate for the age

⁴Some of these data are similar to the special study of the plan's utilization of care for mental conditions that was made for the year 1969 and set forth in L. S. Reed, E. S. Myers, and P. L. Scheideman: *op. cit.*, pp. 214-226.

TABLE 11
Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Enrolled Population, by Age and Sex

Age	Male	Female	Total	Male	Female	Total
<i>Employees and Annuitants, End of 1973</i>				<i>Total Covered Population, End of 1973</i>		
Under 19 (Children)	0	0	0	1,079,255	1,041,088	2,120,343
19-34	247,426	129,541	376,967	294,060	371,833	665,893
35-44	215,376	56,663	272,039	249,692	274,532	524,224
45-54	311,061	101,596	412,657	347,351	350,289	697,640
55-64	227,997	100,760	328,757	253,553	242,508	496,061
65 and over	94,778	67,683	162,461	107,205	118,479	225,684
All ages	1,096,638	456,243	1,552,881	2,331,116	2,398,729	4,729,845
<i>Dependents, End of 1973</i>				<i>Total Covered Population, During 1973</i>		
Under 19 (Children)	1,079,255	1,041,088	2,120,343	1,066,855	1,029,126	2,095,981
19-34	46,634	242,292	288,926	290,681	367,561	658,242
35-44	34,316	217,869	252,185	246,823	271,378	518,201
45-54	36,290	248,693	284,983	343,360	346,264	689,624
55-64	25,556	141,748	167,304	250,640	239,721	490,361
65 and over	12,427	50,796	63,223	105,973	117,118	223,091
All ages	1,234,478	1,942,486	3,176,964	2,304,332	2,371,168	4,675,500

group 19-34 is probably somewhat too high and that for age group 35-44 too low. The rates for both sexes together are probably more reliable than the separate rates for males and females.

In every age group the admission rate was higher among females than males, although the difference was insignificant among children. Overall, the rate for females was 33 percent higher than that for males.

The average length of stay was considerably above average for children and slightly above average for those in the 19-34 bracket. It was higher for males than

females among children and those in the 19-34 age group, and slightly higher among females than males in all other age groups. Overall, the average length of stay was almost the same for males and females.

The days of care rate, largely following the admissions rate, was low among children, highest in the 19-34 age group, somewhat lower among those aged 35-44 and 45-54, and then declined rapidly in the older age groups. The data may be faulty—too low—for those 65 and over. An appreciable proportion of the enrollees aged 65 and over—perhaps as many as 40 percent—was also

TABLE 12
Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Basic Inpatient Hospital Benefits for Mental Disorders,
by Age and Sex (in General Hospitals and Member Mental Hospitals)

Age	Male	Female	Total	Male	Female	Total
<i>Admissions—Rate per 1,000</i>				<i>Average Length of Stay (Days)</i>		
Under 19	1.3	1.4	1.3	27.3	23.8	25.5
19-34	7.1	9.2	8.3	21.0	17.7	19.0
35-44	6.3	10.7	8.6	13.6	15.8	15.1
45-54	7.6	10.1	8.9	13.5	16.4	15.2
55-64	6.7	6.9	6.8	15.0	18.1	16.5
65 and over	3.5	4.0	3.8	17.3	18.4	17.9
All ages	4.2	5.6	4.9	17.5	17.7	17.6
<i>Days of Care—Rate per 1,000</i>				<i>Average Covered Charges per Covered Person</i>		
Under 19	34.7	34.1	34.4	\$2.39	\$2.45	\$2.42
19-34	149.4	163.3	157.2	10.47	11.62	11.11
35-44	86.4	169.5	130.0	5.82	11.46	8.77
45-54	103.4	165.7	134.7	7.08	11.39	9.24
55-64	100.0	125.6	112.5	6.90	9.16	8.00
65 and over	60.9	74.4	68.0	2.66	2.75	2.71
All ages	73.3	100.1	86.9	4.98	6.90	5.95

covered under Medicare, and hence the data may reflect only days paid for by the plan and not by Medicare.

Covered charges per person covered were low among children, highest in the 19-34 age group, and declined in the next three age groups (the figures for the age group 35-44 are possibly too low and those for the age group 19-34 too high). The rate was exceedingly low for those aged 65 and over, and is not a valid figure due to the factor mentioned above.

Table 13 shows, by age and sex, admissions and days of care per 1,000 and covered charges per covered person for all conditions (exclusive of maternity) and for mental conditions, and also shows mental rates as a percent of those for all conditions. The data for mental conditions as a percent of all conditions are valid at all ages, since these are not affected by the possibly faulty estimates of the covered population. Admissions for mental conditions as a percent of those for all conditions (exclusive of maternity) were low for children, were highest for the 19-34 age group, and then declined gradually to a low for the 65-and-over group. There are no significant differences in this respect between the figures for females

and males, though the females had a slightly higher proportion of mental admissions to those for all conditions.

Due to the relatively long length of stay for mental conditions among children and young adults, the days of care per 1,000 for mental conditions as a percent of the total were substantial for those in the younger age groups—14 percent for children and 19 percent in age group 19-34. Among males 19-34, days of care for mental conditions comprised 22 percent of those for all conditions. Since charges per day of care for mental conditions were relatively low in comparison with those for all conditions, covered charges per enrolled person for mental conditions constituted a lower proportion of those for all conditions than was true for days of care. Nevertheless, covered charges for mental conditions were ten percent of those for all conditions among children and almost 13 percent among young adults. The proportion gradually declined to 1.9 percent among those aged 65 and over.

Table 14 shows outpatient admissions under basic hospital benefits and covered charges per covered per-

TABLE 13
Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Hospital Care for Mental Disorders as a Percent of Care for All Conditions,
by Age and Sex (Basic Benefits Only)

Age	Male			Female			Both Sexes		
	All conditions	Mental conditions	Mental as percent of all	All conditions*	Mental conditions	Mental as percent of all	All conditions*	Mental conditions	Mental as percent of all
<i>Admission Rates per 1,000</i>									
Under 19	53.6	1.3	2.4%	47.2	1.4	3.0%	50.5	1.3	2.7%
19-34	100.3	7.1	7.1	155.3	9.2	5.9	131.0	8.3	6.3
35-44	105.6	6.3	6.0	185.6	10.7	5.8	147.5	8.6	5.8
45-54	163.7	7.6	4.7	215.9	10.1	4.7	189.9	8.9	4.7
55-64	212.8	6.7	3.1	200.1	6.9	3.5	206.6	6.8	3.3
65 and over	269.8	3.5	1.3	210.4	4.0	1.9	239.6	3.8	1.6
All ages	108.7	4.2	3.9	128.0	5.6	4.4	118.5	4.9	4.2
<i>Days of Care—Rate per 1,000</i>									
Under 19	268.2	34.7	12.9%	229.9	34.1	14.8%	249.4	34.4	13.8%
19-34	692.1	149.4	21.6	944.3	163.3	17.3	832.9	157.2	18.9
35-44	764.7	86.4	11.3	1,387.5	169.5	12.2	1,090.9	130.0	11.9
45-54	1,365.0	103.4	7.6	1,799.3	165.7	9.2	1,583.1	134.7	8.5
55-64	2,060.7	100.0	4.9	1,968.6	125.6	6.4	2,015.7	112.5	5.6
65 and over	3,065.4	60.9	2.0	2,472.2	74.4	3.0	2,754.0	68.0	2.5
All ages	861.9	73.3	8.5	988.8	100.1	10.1	926.3	86.9	9.4
<i>Covered Charges per Covered Person</i>									
Under 19	\$27.24	\$2.39	8.8%	\$23.35	\$2.45	10.5%	\$25.33	\$2.42	9.6%
19-34	71.25	10.47	14.7	98.65	11.62	11.8	86.55	11.11	12.8
35-44	80.10	5.82	7.3	138.84	11.46	8.3	110.86	8.77	7.9
45-54	149.03	7.08	4.8	182.81	11.39	6.2	165.99	9.24	5.6
55-64	228.98	6.90	3.0	201.87	9.16	4.5	215.73	8.00	3.7
65 and over	174.38	2.66	1.5	108.67	2.75	2.5	139.88	2.71	1.9
All ages	85.31	4.98	5.8	93.79	6.90	7.4	89.61	5.95	6.6

*Exclusive of maternity.

TABLE 14

Blue Cross and Blue Shield Plan for Federal Employees,
High Option, 1973
Basic Hospital Outpatient Benefits for
Mental Disorders, by Age and Sex

Age	Male	Female	Total
<i>Admissions—Rate per 1,000</i>			
Under 19	0.1	0.2	0.2
19-34	0.8	1.1	1.0
35-44	0.6	1.6	1.1
45-54	0.7	1.6	1.1
55-64	0.5	1.3	0.9
65 and over	0.4	1.0	0.7
All ages	0.4	0.8	0.6
<i>Covered Charges per Covered Person</i>			
	a	a	a
Under 19			
19-34	\$0.02	\$0.03	\$0.02
35-44	0.02	0.04	0.03
45-54	0.02	0.04	0.03
55-64	0.01	0.03	0.02
65 and over	0.01	0.01	0.01
All ages	0.01	0.02	0.01

^aLess than one half of one cent.

son. Both admission rates and covered charges are relatively insignificant; age and sex variations are similar to those for inpatient care.

Table 15 shows basic surgical-medical benefits (*i.e.*, in-hospital medical care) for mental disorders by age and sex. The variations by the sex and age groups show about the same pattern as those for basic inpatient hospital care. The male rate for the 19-34 age group is probably somewhat too high, that for the 35-44 group too low, for the reasons mentioned earlier. Likewise, the visit days and benefits for those aged 65 and over are too low because some of this group received Medicare benefits.

Table 16 shows utilization of supplemental benefits by age and sex. Hospital cases per 1,000—these in effect are claims and are for care in nonmember mental hospitals—follow the same general pattern as for basic hospital benefits. Cases and charges were relatively low for children, were highest in the 19-34 age group, fell off in the 35-54 age group, and then declined still further with advancing age.

Utilization of physicians' services—in effect, this is care in the office—varied more widely by age. Among both sexes utilization by children was very low, was at a peak in the 19-34 age group, was lower but still relatively high in the 35-44 age group, and then declined rapidly. Among all age groups except children, utilization was higher among females than males. Total benefits paid per person covered followed the same pattern.

Table 17 shows total benefits paid under both basic and supplemental benefits by age and sex. The age group 19-34 was the highest utilizer of care for mental condi-

TABLE 15

Blue Cross and Blue Shield Plan for Federal Employees,
High Option, 1973
Basic Surgical-Medical Benefits for
Mental Disorders, by Age and Sex

Age	Male	Female	Total
<i>In-Hospital Medical Claims per 1,000</i>			
Under 19	1.3	1.5	1.4
19-34	7.7	9.7	8.8
35-44	6.6	11.8	9.3
45-54	7.4	11.4	9.4
55-64	6.4	7.9	7.2
65 and over	3.3	4.3	3.8
All ages	4.2	6.2	5.2
<i>Visit Days per 1,000</i>			
Under 19	24.5	26.2	25.4
19-34	103.7	123.9	115.0
35-44	70.4	131.4	102.4
45-54	76.8	125.7	101.3
55-64	70.4	94.4	82.2
65 and over	35.7	51.8	44.1
All ages	52.7	76.1	64.6
<i>Benefits Paid per Covered Person</i>			
Under 19	\$0.45	\$0.50	\$0.47
19-34	2.14	2.52	2.35
35-44	1.39	2.72	2.09
45-54	1.49	2.61	2.05
55-64	1.36	1.85	1.60
65 and over	0.50	0.72	0.62
All ages	1.02	1.52	1.28

tions, followed by the age group 35-44, with utilization much lower among those in the older age groups. At all ages except among children, females utilized more care than males.

The reader who is especially interested in the variation in utilization by age and sex would do well to compare the utilization pattern here presented with that shown for 1969 in the Reed, Myers, and Scheidemandel report. In that report a different method was used in estimating the age and sex distribution of dependents. The relationships in the utilization rates of the 19-34 and 35-44 age groups are somewhat different from those shown here, but overall the general pattern was the same.

UTILIZATION BY REGION, 1973

There are wide variations in utilization of care for mental disorders by geographic area, *i.e.*, census division.⁵ It would be interesting to explore these differences

⁵The nine census divisions consist of the following states:
New England: Maine, Massachusetts, Rhode Island, Vermont, New Hampshire, and Connecticut
Middle Atlantic: New York, New Jersey, and Pennsylvania
South Atlantic: District of Columbia, Delaware, Maryland, Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida.

TABLE 16

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Supplemental Benefits for Mental Disorders, by Age and Sex

Age	Males	Females	Total	Males	Females	Total
<i>Hospital Cases per 1,000 Population</i>				<i>Hospital Charges per Person Covered</i>		
Under 19	0.8	0.6	0.7	\$0.98	\$0.74	\$0.87
19-34	2.9	2.4	2.6	3.75	2.28	2.93
35-44	1.2	2.1	1.7	0.92	1.55	1.25
45-54	1.2	2.2	1.7	1.02	1.92	1.47
55-64	1.1	1.5	1.3	1.02	1.60	1.30
65 and over	0.8	1.0	0.9	1.02	1.29	1.16
All ages	1.2	1.4	1.3	1.34	1.36	1.35
<i>Physicians' Services—Cases per 1,000 Population</i>				<i>Physicians' Charges per Person Covered</i>		
Under 19	7.1	4.8	6.0	\$1.61	\$1.10	\$1.36
19-34	44.9	59.1	52.8	13.85	15.95	15.02
35-44	32.7	44.0	38.6	9.38	10.64	10.04
45-54	17.3	26.3	21.8	3.78	5.50	4.65
55-64	8.7	13.7	11.1	1.62	2.70	2.15
65 and over	3.2	5.7	4.5	0.37	0.53	0.46
All ages	16.1	21.8	19.0	4.26	5.27	4.77
<i>Total Supplemental Benefits Paid by Program per Person Covered</i>						
	<u>Males</u>	<u>Females</u>	<u>Total</u>			
Under 19	\$2.45	\$1.71	\$2.08			
19-34	15.01	15.80	15.45			
35-44	8.78	10.77	9.82			
45-54	4.14	6.83	5.49			
55-64	2.33	3.91	3.10			
65 and over	1.42	2.30	1.88			
All ages	4.90	5.93	5.42			

in depth and find the reasons for them. However, limitations of time and money permit no more than a presentation of the basic figures.

Hospital admissions under basic hospital benefits (*i.e.*, in general hospitals and member mental hospitals) varied from a low of 2.6 (per 1,000 population) in the New England region and 3.5 in the Middle Atlantic region to a high of 7.5 in the West North Central states and 6.9 in the East South Central states, with virtually the same figure (6.8) in the West South Central states (Table 18). These rates may be affected somewhat by the extent to which mental hospitals in the various regions are or are not member hospitals of the local Blue Cross plans. The average length of stay varied less widely, ranging from a low of 13.9 days in the Mountain states to a high of 22.1 in the Middle Atlantic states. Days of care per 1,000 population were lowest in New England (48.3), next lowest in the Pacific states (72.9) and Middle Atlantic states (77.4). Days of care were highest in the

West North Central and West South Central states—both a little over 125 days.

Hospital care benefits per person covered were lowest in New England (\$3.96), with the Pacific, Mountain, South Atlantic, and Middle Atlantic states all in the \$5.51-\$5.72 range. Benefits per person covered were highest in the West North Central and West South Central areas—\$7.80 and \$7.45 respectively.

Basic surgical-medical benefits per covered person varied quite widely from a low of \$2.27 in the New England states to a high of \$2.43 in the West South Central states.

TABLE 17

Blue Cross and Blue Shield Plan for Federal Employees,
High Option, 1973
All Benefits Paid for Mental Disorders per
Person Covered, by Age and Sex

Age	Male	Female	Total
Under 19	\$5.29	\$4.67	\$4.98
19-34	27.63	29.96	28.93
35-44	16.01	24.99	20.71
45-54	12.73	20.87	16.82
55-64	10.60	14.95	12.73
65 and over	4.59	5.79	5.22
All ages	10.91	14.37	12.67

East North Central: Ohio, Indiana, Illinois, Michigan, and Wisconsin.
East South Central: Kentucky, Tennessee, Alabama, and Mississippi.
West North Central: Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas.
West South Central: Arkansas, Louisiana, Oklahoma, and Texas.
Mountain: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, and Nevada.
Pacific: California, Washington, Oregon, Alaska, and Hawaii.

TABLE 18
Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
All Benefits for Mental Disorders, by Region

Region (census division)	Basic Hospital Benefits							Basic Surgical- Medical Benefits			Supplemental Benefits			All Benefits		
	Covered popu- lation (000)	Admissions		Days of care		Average length of stay (days)	Benefits		Amount (000)	Per covered person	Amount (000)	Per covered person	Amount (000)	Per covered person	Amount (000)	Per covered person
		Number	Per 1,000 popu- lation	Number	Per 1,000 popu- lation		Amount (000)	Per covered person								
New England	285.2	742	2.6	13,771	48.3	18.6	\$1,129.0	\$3.96	\$78.0	\$0.27	\$1,732.4	\$6.07	\$2,939.4	\$10.31	\$2,939.4	\$10.31
Middle Atlantic	573.2	2,007	3.5	44,353	77.4	22.1	3,279.7	5.72	297.5	0.52	2,958.2	5.16	6,535.4	11.40	6,535.4	11.40
East North Central	574.9	2,438	4.2	50,920	88.6	20.9	4,001.5	6.96	712.1	1.24	1,414.0	2.46	6,127.7	10.66	6,127.7	10.66
West North Central	309.1	2,324	7.5	38,925	125.9	16.7	2,410.3	7.80	419.3	1.36	826.7	2.67	3,656.3	11.83	3,656.3	11.83
South Atlantic	1,420.6	6,519	4.6	113,397	79.8	17.4	8,019.9	5.65	2,167.7	1.53	13,700.7	9.64	23,888.3	16.82	23,888.3	16.82
D.C., Md., & Va.	(982.0)	(3,742)	(3.8)	(78,575)	(80.0)	(21.0)	(6,038.8)	(6.15)	(1,676.3)	(1.71)	(12,763.9)	(13.00)	(20,478.9)	(20.86)	(20,478.9)	(20.86)
Other South Atlantic states	(438.6)	(2,777)	(6.3)	(34,822)	(79.4)	(12.5)	(1,981.2)	(4.52)	(491.4)	(1.12)	(936.8)	(2.14)	(3,409.4)	(7.77)	(3,409.4)	(7.77)
East South Central	283.5	1,962	6.9	29,013	102.3	14.8	1,665.9	5.88	448.9	1.58	345.7	1.22	2,460.5	8.68	2,460.5	8.68
West South Central	455.8	3,105	6.8	57,126	125.3	18.4	3,395.2	7.45	1,109.2	2.43	1,469.4	3.22	5,973.8	13.11	5,973.8	13.11
Mountain	353.1	2,258	6.4	31,389	88.9	13.9	1,963.8	5.56	445.3	1.26	938.8	2.66	3,347.9	9.48	3,347.9	9.48
Pacific	361.7	1,623	4.5	26,356	72.9	16.2	1,991.8	5.51	286.9	0.79	1,920.4	5.31	4,199.2	11.61	4,199.2	11.61
All United States	4,617.0*	22,978	5.0	405,250	87.8	17.6	27,857.2	6.03	5,964.9	1.29	25,306.3	5.48	59,128.4	12.81	59,128.4	12.81

*Exclusive of 34,800 covered persons in Puerto Rico, U.S. territories, and foreign countries.

Supplemental benefits paid per person—such benefits are mainly for care in physicians' offices and hospital care in nonmember mental hospitals—varied in quite different ways from the utilization of hospital care under basic benefits. These supplemental benefits were lowest in the East South Central states (\$1.22 per person covered), and next lowest in the East North Central, Mountain, and West North Central states (\$2.46–\$2.67). Benefits were highest in the South Atlantic region—\$9.64 per covered person, with a figure of \$13.00 in the area comprised of the District of Columbia, Maryland, and Virginia and \$2.14 in the other states of the South Atlantic region. (Separate figures were compiled for the District of Columbia, Maryland, and Virginia because of the large numbers of federal employees in these jurisdictions, concentrated largely, of course, in the District of Columbia metropolitan area; separate data for the latter area by itself could not be compiled.) Supplemental benefits were next highest in the New England region (\$6.07 per person), followed by the Pacific states (\$5.31).

There is some indication from these figures that states with relatively high utilization of hospital care benefits for mental conditions are low utilizers of care in physicians' offices for these conditions, and vice versa. At any rate, there is an indication that areas with above average utilization of office care for mental disorders are moderate or low utilizers of hospital care for these conditions.

Total benefits (basic and supplemental together) for mental disorders per covered person were highest by far in the South Atlantic division (\$16.82—\$20.86 for the District of Columbia, Maryland, and Virginia area and \$7.77 for the other states in the division), followed by the West South Central states (\$13.11). Total benefits were

lowest in the East South Central and Mountain states (\$8.68 and \$9.48 respectively).

Tables 19 and 20 shed a little more light on variations in regional utilization of care for mental conditions, or perhaps merely show how complex the situation is. Hospital admissions and days of care for mental conditions under basic benefits were above average in the West North Central, East South Central, and West South Central states. But these regions were also characterized by hospital utilization rates for all conditions that were much above average (Table 19). The variation in hospital utilization rates for all conditions among the different regions raises, it would seem, almost as much question as the variation in utilization rates for mental conditions.

Charges per covered person for physicians' services for care of mental disorders under supplemental benefits varied widely from region to region. (These are reimbursable charges before application of the deductible and coinsurance.) They were highest by far in the South Atlantic region—an average of \$8.71 for the region, but \$11.82 in the District of Columbia, Maryland, and Virginia area and \$1.74 in the other states in the region. They were next highest in the Pacific and Middle Atlantic states (\$5.30 and \$4.58 respectively). Both of these regions have relatively large numbers of psychiatrists in relation to population, and the District of Columbia metropolitan area has one of the highest ratios of psychiatrists to population among all metropolitan areas in the country.

The areas with the lowest charges per covered person were the East South Central and West North Central states, \$3.90 and \$1.81. Charges for physicians' care of mental conditions under supplemental benefits com-

TABLE 19
Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Basic Hospital Benefits for All and for Mental Conditions, by Region

Region (census division)	All condi- tions	Mental condi- tions	Mental as percent of all	All condi- tions	Mental condi- tions	Mental as percent of all	All condi- tions	Mental condi- tions	Mental as percent of all
<i>Hospital Admissions—Rate per 1,000</i>			<i>Days of Care—Rate per 1,000</i>			<i>Covered Charges per Covered Person</i>			
New England	106.4	2.6	2.4%	906.7	48.3	5.3%	\$102.26	\$3.95	3.9%
Middle Atlantic	101.1	3.5	3.5	941.0	77.4	8.2	100.98	5.71	5.7
East North Central	108.0	4.2	3.9	944.5	88.6	9.4	96.44	6.94	7.2
West North Central	136.9	7.5	5.5*	1,047.1	125.9	12.0	89.51	7.78	8.7
South Atlantic	112.4	4.6	4.1	881.2	79.8	9.1	82.30	5.64	6.8
D.C., Md., and Va.	(99.1)	(3.8)	(3.8)	(815.0)	(80.0)	(9.8)	(80.94)	(6.14)	(7.6)
Other South Atlantic states	(142.2)	(6.3)	(4.5)	(1,029.6)	(79.4)	(7.7)	(85.33)	(4.50)	(5.3)
East South Central	148.3	6.9	4.7	1,110.0	102.3	9.2	90.01	5.86	6.5
West South Central	153.6	6.8	4.4	1,090.7	125.3	11.5	92.10	7.44	8.1
Mountain	124.9	6.4	5.1	829.6	88.9	10.7	79.45	5.54	7.0
Pacific	117.5	4.5	3.8	793.9	72.9	9.2	96.93	5.49	5.7
All United States	119.4	5.0	4.2	933.1	87.8	9.4	90.46	6.02	6.7

TABLE 20
Blue Cross and Blue Shield Plan for Federal
Employees, High Option, 1973
Charges for Physicians' Services Under Supplemental
Benefits, All and Mental Conditions, by Region

Region (census division)	Charges per Person Covered		
	All conditions	Mental conditions	Mental as percent of all
New England	\$7.81	\$3.98	50.9%
Middle Atlantic	9.38	4.58	48.8
East North Central	6.34	2.41	38.0
West North Central	6.34	1.81	28.6
South Atlantic	13.68	8.71	63.7
D.C., Md., and Va.	(16.90)	(11.82)	(69.9)
Other South Atlantic states	(6.45)	(1.74)	(27.0)
East South Central	5.64	0.90	15.9
West South Central	8.91	2.41	27.0
Mountain	7.59	2.57	33.8
Pacific	14.07	5.30	37.7
All United States	9.98	4.82	48.3%

prised almost 70 percent of all charges for physicians' care under supplemental benefits in the District of Columbia, Maryland, and Virginia area. The next highest such ratio was in the New England states—50.9 percent.

The regional pattern of utilization found in this study was quite similar to that found in 1969, as set forth in the Reed, Myers, and Scheidemandel report.

DURATION OF HOSPITAL STAY

Table 21 shows the distribution of admissions, days of care, and covered charges for mental disorders under basic hospital benefits according to duration of stay.

Of all admissions of both sexes, 17.6 percent had a stay of one to three days, and 28.3 had stays of four to nine days. Of the remainder, 38.2 percent had stays of ten to 30 days, 12.9 percent had stays of 31 to 70 days, and 3.0 percent stayed 71 or more days.

Of the total days of care, 51.1 percent resulted from stays of 30 or fewer days, 31.7 percent from stays of 31 to 70, and 17.1 percent from stays of longer than 70 days.

Some local Blue Cross plans (as well as other insurers) place special limits on hospital care for mental conditions. It is possible to compute from this table the effect in savings of days or covered charges of any limitation that might be placed upon length of stay. For example, limiting benefit days to no more than 70 in any admission would reduce total days paid for by five percent.

Table 22 shows a similar distribution of admissions, days of care, and covered charges under basic hospital

benefits for all conditions, by duration of stay, so as to permit a comparison of mental and all conditions.

Some Blue Cross plans (and other insurance plans), in order to reduce their potential costs for mental conditions, limit benefits to no more than a certain number of days per year. Table 23 sheds light on the effect of such limitations in reducing days of care for which a plan might be responsible. It shows the distribution of different persons who had any inpatient care for mental conditions under basic hospital benefits by total number of days of care during the year.

There were 23,053 admissions for mental conditions (Table 21) during the year. Table 23 shows that the number of different persons hospitalized was 17,092, indicating that 5,961 or 26 percent of the admissions were admissions of persons previously admitted that year. Of the total number of persons hospitalized for mental conditions, 20.4 percent had one to four days of such hospital care during the year, 56.2 percent had a total of five to 30 days, 17.0 percent a total of 31 to 70 days, and 6.4 percent had 71 or more days of care during the year. Persons with 30 or fewer days of care for mental conditions during the year were responsible for 35.6 percent of the total days of care for all patients, those with 31 to 70 days had 31.9 percent of total days, and those with 71 or more days of care used 32.4 percent of the total days of care. It may be calculated that limiting benefits to no more than 70 days of care in a year would have reduced total benefit days by about 13.7 percent.

DISTRIBUTION OF DIFFERENT PERSONS WITH PHYSICIANS' CHARGES FOR OFFICE CARE OF MENTAL DISORDERS BY AMOUNT OF CHARGES

This section presents data on the distribution of persons who under supplemental benefits submitted claims for reimbursement of physicians' charges for care of mental disorders by amount of such charges. From the data, inferences can be made as to distribution of patients by number of office visits. The data are for the high option and relate only to services of physicians—they do not include charges of psychologists.

It will be recalled that the plan under its high option supplemental benefits paid 80 percent of charges, in excess of a deductible of \$100 per person per year, for physicians' services and hospital care not covered under basic benefits and for drugs, special nursing, and certain other items of care. Since charges for physicians' services for in-hospital care were paid under basic surgical-medical benefits, and since in virtually all jurisdictions in 1973 the plan paid physicians on the basis of usual, customary, and reasonable charges, it may be assumed that these charges, for all practical purposes, were paid in full and that only negligible, if any, charges for

TABLE 21

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Admissions, Days of Care, and Total Covered Charges for Mental Conditions,
by Duration of Stay and Sex (Basic Hospital Benefits Only)

Duration of stay	Male			Female			Total		
	Number or amount	Percent of total	Cumulative percent	Number or amount	Percent of total	Cumulative percent	Number or amount	Percent of total	Cumulative percent
<i>Admissions</i>									
1 day	569	5.9%	5.9%	887	6.5%	6.6%	1,456	6.3%	6.3%
2 days	557	5.8	11.7	677	5.1	11.7	1,234	5.4	11.7
3 days	656	6.8	18.4	719	5.4	17.0	1,375	6.0	17.6
4-5 days	1,148	11.9	30.3	1,480	11.1	28.1	2,628	11.4	29.0
6-9 days	1,737	18.0	48.3	2,148	16.0	44.1	3,885	16.9	45.9
10-14 days	1,365	14.1	62.4	1,924	14.4	58.5	3,289	14.3	60.2
15-30 days	2,136	22.1	84.5	3,384	25.3	83.8	5,520	23.9	84.1
31-70 days	1,166	12.1	96.6	1,816	13.6	97.3	2,982	12.9	97.0
71-120 days	256	2.6	99.3	306	2.3	99.6	562	2.4	99.5
121 days and over	71	0.7	100.0	51	0.4	100.0	122	0.5	100.0
Total	9,661	100.0	100.0	13,392	100.0	100.0	23,053	100.0	100.0
<i>Days of Care</i>									
1 day	554	0.3%	0.3%	872	0.4%	0.4%	1,426	0.4%	0.4%
2 days	1,114	0.7	1.0	1,354	0.6	0.9	2,468	0.6	1.0
3 days	1,968	1.2	2.2	2,157	0.9	1.8	4,125	1.0	2.0
4-5 days	5,150	3.1	5.2	6,598	2.8	4.6	11,748	2.9	4.9
6-9 days	12,704	7.5	12.7	15,911	6.7	11.3	28,615	7.0	11.9
10-14 days	16,221	9.6	22.3	22,876	9.6	21.0	39,097	9.6	21.5
15-30 days	46,448	27.5	49.9	73,735	31.1	52.0	120,183	29.6	51.1
31-70 days	50,216	29.7	79.6	78,677	33.2	85.2	128,893	31.7	82.9
71-120 days	23,188	13.7	93.3	26,939	11.4	96.6	50,127	12.3	95.2
121 days and over	11,236	6.7	100.0	8,175	3.4	100.0	19,411	4.8	100.0
Total	168,799	100.0	100.0	237,294	100.0	100.0	406,093	100.0	100.0
<i>Total Covered Charges</i>									
1 day	\$61,953	0.5%	0.5%	\$97,556	0.6%	0.6%	\$159,509	0.6%	0.6%
2 days	107,386	0.9	1.5	140,277	0.9	1.5	247,663	0.9	1.5
3 days	164,199	1.4	2.9	183,950	1.1	2.6	348,149	1.3	2.7
4-5 days	407,692	3.6	6.5	513,113	3.1	5.7	920,805	3.3	6.0
6-9 days	912,299	8.0	14.4	1,161,414	7.1	12.8	2,073,713	7.4	13.5
10-14 days	1,103,136	9.6	24.0	1,594,211	9.7	22.5	2,697,347	9.7	23.2
15-30 days	3,148,394	27.4	51.5	5,042,775	30.8	53.4	8,191,169	29.4	52.6
31-70 days	3,476,537	30.3	81.8	5,486,927	33.5	86.9	8,963,464	32.2	84.8
71-120 days	1,554,323	13.5	95.3	1,804,141	11.0	97.9	3,358,464	12.1	96.8
121 days and over	538,239	4.7	100.0	343,581	2.1	100.0	881,820	3.2	100.0
Total	11,474,158	100.0	100.0	16,367,945	100.0	100.0	27,842,103	100.0	100.0

inpatient care were submitted for reimbursement under supplemental benefits. Hence for all practical purposes the data represent different persons with charges for outpatient psychiatric care.

Table 24 shows the distribution of enrollees, spouses, nonspouse dependents (children), and all participants by amount of charges in 1973. The significant data are for all participants. In 1973 there were 29,541 different persons out of the covered population of 4,675,500 who, on claims submitted under supplemental benefits, had charges for physicians' care of mental disorders. These persons constituted 6.3 per 1,000 of the covered population, or 0.6 of one percent. Total covered charges amounted to \$22,357,102. (Total benefits payable would be something less than 80 percent because of the \$100 deductible.) These covered charges amounted to \$4.78 per person of the covered population. It should be

understood that the number of persons incurring physicians' charges for outpatient care of mental disorders and the total of such charges were slightly larger than these figures indicate, since if a person had only one or two visits to a psychiatrist, incurred charges of less than \$100, and had no other charges for physicians' care for other conditions or for drugs, etc., making his total reimbursable charges less than \$100, he would probably not submit a claim, or, if he did, the claim would not appear in these statistics. Also, the data include only that portion of charges judged to be reimbursable, i.e., any part of a physician's charge considered to be in excess of the usual, customary, and reasonable charge for the service would not be included.

Of all persons with physicians' charges for mental disorders under supplemental benefits, 62.2 percent had charges of less than \$500. Assuming an average charge of

TABLE 22

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Admissions, Days of Care, and Covered Charges for All Conditions,*
by Duration of Stay (Basic Hospital Benefits Only)

Duration of stay	Admissions			Days of Care			Covered Charges		
	Number	Percent	Cumulative percent	Number	Percent	Cumulative percent	Amount (000)	Percent	Cumulative percent
1 day	54,527	9.8%	9.8%	49,710	1.1%	1.1%	\$9,963	2.4%	2.4%
2 days	86,470	15.6	25.5	172,940	4.0	5.1	24,062	5.7	8.1
3 days	58,810	10.6	36.1	176,430	4.1	9.2	20,242	4.8	13.0
4-5 days	93,722	16.9	53.0	418,171	9.7	18.9	42,078	10.0	23.0
6-9 days	123,120	22.2	75.2	901,663	20.8	39.7	65,436	20.4	43.4
10-14 days	66,902	12.1	87.3	778,079	18.0	57.7	73,511	17.5	60.9
15-30 days	55,607	10.0	97.3	1,119,050	25.8	83.5	105,660	25.2	86.2
31-70 days	13,250	2.4	99.7	554,558	12.8	96.3	48,555	11.6	97.7
71-120 days	1,356	0.2	99.96	119,023	2.7	99.0	8,075	1.9	99.7
121 days and over	241	<0.05	100.0	41,212	1.0	100.0	1,397	0.3	100.0
Total	554,005	100.0	100.0	4,330,836	100.0	100.0	418,979	100.0	100.0

*Exclusive of maternity.

\$35 per visit, they probably had less than 14 or 15 visits during the year. Their charges amounted to 15.2 percent of the total charges. Another 28.5 percent had charges of \$500 to \$1,999, or roughly between 14 and 57 visits during the year. The charges of this group amounted to 38.3 percent of the total charges. Another 7.2 percent had charges of \$2,000 to \$4,999 during the year, or roughly from about 57 to 143 visits during the year. The charges of this group amounted to 29.1 percent of the total charges. Finally, 2.0 percent had charges of \$5,000 and over (running up to one person with total charges of

\$15,572). Their charges amounted to 17.4 percent of all physicians' charges for mental disorders under supplemental benefits.

The average charge per person with charges was \$756.82; the median charge was \$383.66, i.e., one half of the persons had charges under and one half over this amount.

The separate data for enrollees (i.e., the subscribing employee or annuitant), spouses of enrollees, and non-spouse dependents (children under 19, or over 19 if attending school) indicate that relatively fewer of the

TABLE 23

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Distribution of Different Persons by Number of Days of
Inpatient Stay Under Basic Hospital Benefits

Duration of stay	Different persons		Total days		Days per person	Total covered charges
	Number	Percent	Number	Percent		
1 day	904	5.3%	904	0.2%	1.0	\$103,329
2 days	800	4.7	1,600	0.4	2.0	163,021
3-4 days	1,788	10.5	6,244	1.5	3.5	527,459
5-9 days	3,357	19.6	22,932	5.6	6.8	1,727,121
10-14 days	2,229	13.0	28,492	6.5	11.9	1,874,157
15-30 days	4,024	23.5	86,948	21.4	21.6	5,926,814
31-45 days	1,687	9.9	62,370	15.3	37.0	4,253,552
46-50 days	367	2.1	17,629	4.3	48.0	1,165,177
51-70 days	845	4.9	50,077	12.3	59.3	3,468,700
71-120 days	720	4.2	64,696	15.9	89.9	4,286,199
121-240 days	312	1.8	50,071	12.3	160.5	3,325,512
241-360 days	53	0.3	15,019	3.7	283.4	922,487
Over 360 days	6	a	2,184	0.5	364.0	156,778
Total	17,092	100.0	407,166	100.0	23.8	27,900,306

a Less than one tenth of one percent.

TABLE 24

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Distribution of Different Persons with Physicians' Charges for Care of
Mental Disorders Under Supplemental Benefits, by Amount of Charges

Amount of charges	Enrollees		Spouses		Nonspouse dependents		All participants	
	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered
Under \$100	2,390	\$113,319	2,341	\$111,723	1,217	\$57,761	5,948	\$282,803
\$100- 499	4,732	1,191,114	4,468	1,101,255	3,240	828,519	12,440	3,120,888
\$500- 999	1,929	1,384,817	1,554	1,105,338	1,251	893,624	4,734	3,383,779
\$1,000- 1,999	1,731	2,461,901	1,124	1,562,020	836	1,160,473	3,691	5,184,394
\$2,000- 2,999	618	1,510,371	345	844,195	200	479,252	1,163	2,833,818
\$3,000- 4,999	581	2,214,137	294	1,090,205	98	366,974	973	3,671,316
\$5,000- 6,999	289	1,707,075	87	514,861	42	238,491	418	2,460,427
\$7,000- 9,999	120	951,256	35	271,019	8	68,338	163	1,290,613
\$10,000-14,999	6	67,762	3	34,085	1	11,645	10	113,492
\$15,000-19,999	1	15,572	—	—	—	—	1	15,572
Total	12,397	11,617,324	10,251	6,634,701	6,893	4,105,077	29,541	22,357,102
Percentage distribution								
Under \$100	19.3	1.0	22.8	1.7	17.7	1.4	20.1	1.3
\$100- 499	38.2	10.3	43.6	16.6	47.0	20.2	42.1	14.0
\$500- 999	15.6	11.9	15.2	16.7	18.1	21.8	16.0	15.1
\$1,000- 1,999	14.0	21.2	11.0	23.5	12.1	28.3	12.5	23.2
\$2,000- 2,999	5.0	13.0	3.4	12.7	2.9	11.7	3.9	12.7
\$3,000- 4,999	4.7	19.1	2.9	16.4	1.4	8.9	3.3	16.4
\$5,000- 6,999	2.3	14.7	0.8	7.8	0.6	5.8	1.4	11.0
\$7,000- 9,999	1.0	8.2	0.3	4.1	0.1	1.7	0.6	5.8
\$10,000-14,999	a	0.6	a	0.5	a	0.3	a	0.5
\$15,000-19,999	a	0.1	—	—	—	—	a	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total population covered							4,675,500	
Number of persons with charges per 1,000 population covered							6.3	
Amount of charges per person covered								\$4.78
Average charge per person with charges	\$937.11		\$647.22		\$595.54		\$756.82	
Median charge (estimated)							\$383.66	
a Less than .05 percent.								

^a Less than .05 percent.

enrollees than of the spouses or children had charges of less than \$500—57.4 percent of the enrollees as against 66.4 percent of the spouses and 64.7 percent of the children. On the other hand, relatively more of the enrollees than of spouses and children had high charges, i.e., 3.4 percent of enrollees had charges of \$5,000 and over as compared with 1.2 percent of the spouses and 0.7 percent of the children.

Table 25 shows similar data for all participants for each of the years 1971, 1972, and 1973, and for the three-year period 1971-73, inclusive. The data show a slightly larger number of persons per 1,000 with supplemental physicians' charges for mental disorders in 1972 than in 1971, but a decrease from 1972 to 1973. Average charges per capita of the covered population increased from 1971 to 1972 but declined slightly in 1973. Average charges per person with charges increased slightly from 1971 to 1972 and from 1972 to 1973. Some increase would be

expected due to increase of physicians' charges per visit over this period.

The data show some increase during the three years in the proportion of persons with charges of \$5,000 and over. Thus 1.7 percent of all persons with charges had charges of \$5,000 and over in 1971; their charges were 14.7 percent of the total. In 1972, 1.8 percent had charges of over \$5,000, with total charges of 15.7 percent of the total. In 1973, two percent had charges of \$5,000 and over and their charges amounted to 17.4 percent of total charges.

The more significant figures are those for the three-year period, 1971-73, which show different persons who had charges during this period distributed according to total charges during the period. This, in some ways, shows a more accurate picture of the utilization of care than figures for any one year, since in any one year persons beginning or ending long-term intensive therapy

TABLE 25

Blue Cross and Blue Shield Plan for Federal Employees, High Option
Distribution of Different Persons with Physicians' Charges for Care of Mental Disorders
Under Supplemental Benefits, by Amount of Charges, 1971, 1972, 1973, and 1971-73

Amount of charges	1971		1972		1973		1971-73	
	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered
Under \$100	5,421	\$262,871	5,840	\$279,455	5,948	\$282,803	10,544	\$505,287
\$100- 499	10,856	2,701,663	12,517	3,140,714	12,440	3,130,886	24,165	6,085,608
\$500- 999	4,154	2,950,806	4,609	3,275,880	4,734	3,383,779	8,439	6,281,081
\$1,000- 1,999	3,029	4,219,328	3,357	4,685,594	3,691	4,894,364	6,477	9,122,586
\$2,000- 2,999	1,021	2,500,844	1,100	2,695,344	1,163	2,831,818	2,756	6,718,548
\$3,000- 4,999	809	3,098,421	905	3,448,606	973	3,671,316	2,756	9,381,794
\$5,000- 6,999	351	2,049,246	393	2,307,096	418	2,460,427	1,147	8,003,351
\$7,000- 9,999	82	634,435	108	863,520	163	1,290,613	277	6,171,835
\$10,000-14,999	2	26,047	8	90,804	10	113,492	221	3,811,734
\$15,000-19,999	—	—	—	—	1	15,572	67	1,504,104
\$20,000 and over	—	—	—	—	—	—	57,748	61,559,935
Total	25,725	18,443,661	28,838	20,787,013	29,541	22,357,102	—	—
<i>Percentage distribution</i>								
Under \$100	21.1	1.4	20.3	1.3	20.1	1.3	18.3	0.8
\$100- 499	42.2	14.6	43.4	15.1	42.1	14.0	41.8	9.9
\$500- 999	16.1	16.0	16.0	15.8	16.0	15.1	15.3	10.2
\$1,000- 1,999	11.8	22.9	11.6	22.5	11.2	23.2	11.2	14.8
\$2,000- 2,999	4.0	13.6	3.8	13.0	3.9	12.7	4.8	10.9
\$3,000- 4,999	3.1	16.8	3.1	16.6	3.3	16.4	4.2	15.2
\$5,000- 6,999	1.4	11.1	1.4	11.1	1.4	11.0	1.6	9.1
\$7,000- 9,999	0.3	3.4	0.4	4.2	0.6	5.8	1.3	10.4
\$10,000-14,999	^a	0.1	^a	0.4	^a	0.5	0.9	10.0
\$15,000-19,999	—	—	—	—	^a	—	0.4	6.2
\$20,000 and over	—	—	—	—	—	—	0.1	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total population covered	4,506,000		4,339,931		4,675,500		4,538,700	
Number of persons with charges per 1,000 population covered	5.7		6.5		6.3		12.7 ^b	
Amount of charges per person covered		\$4.09		\$4.79		\$4.78		\$13.56
Average charge per person with charges		\$716.95		\$720.82		\$756.82		\$1,066.01
Median charges (estimated)		\$374.17		\$374.14		\$383.66		\$403.40

^a Less than .05 percent.^b Annualized average rate would be one third of this figure.

TABLE 26
Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1973
Distribution of Different Persons with Physicians' Charges for Care of Mental
Disorders Under Supplemental Benefits, by Amount of Charges, in the
District of Columbia, Maryland, and Virginia, and Ohio, California, and the United States

Amount of charges	D.C., Maryland, and Virginia		Ohio		California		United States	
	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered
Under \$100	1,757	\$83,416	314	\$15,204	330	\$16,782	5,948	\$287,803
\$100- 499	4,077	1,511,568	440	102,217	987	247,358	12,440	3,120,898
\$500- 999	2,105	1,515,782	104	71,619	368	265,465	4,734	3,383,779
\$1,000- 1,999	1,989	2,806,694	43	57,633	281	405,509	3,691	5,184,394
\$2,000- 2,999	686	1,677,933	12	28,718	74	181,283	1,163	2,833,818
\$3,000- 4,999	592	2,220,457	17	72,348	56	209,729	973	3,671,316
\$5,000- 6,999	260	1,534,210	14	80,854	26	150,236	418	2,460,427
\$7,000- 9,999	82	650,451	6	46,700	20	105,441	163	1,290,613
\$10,000-14,999	5	57,597	—	—	4	45,645	10	115,492
\$15,000-19,999	—	—	—	—	1	15,572	1	15,572
Total	11,563	11,621,198	956	475,293	2,147	1,705,070	29,541	22,357,102
<i>Percentage distribution</i>								
Under \$100	15.3	0.7	32.8	3.2	15.4	1.0	20.1	1.3
\$100- 499	35.3	9.2	46.7	21.5	46.0	14.5	42.1	14.0
\$500- 999	18.2	13.1	10.9	15.1	17.1	15.6	16.0	15.1
\$1,000- 1,999	17.2	24.1	4.5	12.1	13.1	23.8	12.5	23.2
\$2,000- 2,999	5.9	14.4	1.3	6.0	3.4	10.7	3.9	12.7
\$3,000- 4,999	5.1	19.1	1.8	15.2	2.6	12.3	3.3	16.4
\$5,000- 6,999	2.2	13.2	1.5	17.0	1.2	8.8	1.4	11.0
\$7,000- 9,999	0.7	5.6	0.6	9.8	0.9	9.7	0.6	5.8
\$10,000-14,999	a	0.5	—	—	a	2.7	a	0.5
\$15,000-19,999	—	—	—	—	a	0.9	a	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total population covered	987,000		175,400		288,100		4,675,500	
Number of persons with charges per 1,000 population covered	11.7		5.5		7.5		6.3	
Amount of charges per person covered		\$11.77		\$2.71		\$5.92		\$4.78
Average charge per person with charges		\$1,005.03		\$497.17		\$794.14		\$756.82
Median charges (estimated)		\$493.85		\$247.07		\$401.30		\$383.66

a Less than .05.

TABLE 27

Blue Cross and Blue Shield Plan for Federal Employees, High Option, 1971-73
Distribution of Different Persons with Physicians' Charges for Care of Mental
Disorders Under Supplemental Benefits, by Amount of Charges, in the
District of Columbia, Maryland, and Virginia, and Ohio, California, and the United States

Amount of charges	D.C., Maryland, and Virginia		Ohio		California		United States	
	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered	Number of persons	Amount covered
Under \$100	2,930	\$141,201	643	\$31,609	677	\$33,986	10,544	\$505,287
\$100- 499	7,441	1,924,832	1,106	260,932	1,899	486,740	24,165	6,066,608
\$500- 999	3,473	2,487,051	293	207,806	975	479,467	8,639	6,281,081
\$1,000- 1,999	2,982	4,245,804	161	227,748	1,748	423,631	6,477	9,122,586
\$2,000- 2,999	1,460	3,561,378	49	117,438	199	637,076	2,756	6,716,548
\$3,000- 4,999	1,403	5,401,168	37	138,038	166	657,484	2,452	9,381,794
\$5,000- 6,999	580	3,409,751	13	79,137	70	418,129	97	5,381,007
\$7,000- 9,999	472	3,934,849 *	23	193,411	46	399,634	767	6,811,077
\$10,000-14,999	315	3,806,305	7	224,271	31	377,003	511	6,177,835
\$15,000-19,999	153	2,650,768	7	117,265	11	190,569	221	3,811,734
\$20,000 and over	51	1,140,798	3	69,383	4	91,980	67	1,504,104
Total	21,260	32,703,915	2,352	1,666,534	4,297	4,303,052	57,748	61,559,935
Percentage distribution								
Under \$100	13.8	0.4	27.3	1.9	15.8	0.8	18.3	0.8
\$100- 499	35.0	5.9	47.0	15.6	44.2	11.3	41.8	9.9
\$500- 999	16.3	7.6	12.5	13.7	15.7	11.1	15.3	10.2
\$1,000- 1,999	14.0	13.0	6.8	12.5	12.1	16.8	11.2	14.8
\$2,000- 2,999	6.9	10.9	2.1	7.0	4.6	11.3	4.8	10.9
\$3,000- 4,999	6.6	16.5	1.6	8.3	3.9	14.5	4.2	15.2
\$5,000- 6,999	2.7	10.4	0.6	4.7	1.6	9.7	1.6	9.1
\$7,000- 9,999	2.2	12.0	1.0	11.6	1.1	9.1	1.3	10.4
\$10,000-14,999	1.5	11.6	0.7	13.5	0.7	8.8	0.9	10.0
\$15,000-19,999	0.7	8.1	0.3	7.0	0.3	4.4	0.4	6.2
\$20,000 and over	0.2	3.5	0.1	4.2	0.1	2.1	0.1	2.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total population covered	960,800		172,200		292,000		4,538,700	
Number of persons with charges per 1,000 population covered	22.1 ^a		13.7 ^a		14.7 ^a		12.7 ^a	
Amount of charges per person covered		\$34,04 ^a		\$9,68 ^a		\$14,74 ^a		\$13,56 ^a
Average charge per person with charges		\$1,538.28		\$708.56		\$1,001.41		\$1,066.01
Median charges (estimated)		\$537.28		\$292.75		\$409.93		\$403.40

^aAnnualized average rate would be one third of this figure.

or analysis may show up in that year as having relatively low charges.

It will be seen that in the three-year period, 60.1 percent of all persons who incurred supplemental physicians' charges for care of mental disorders incurred charges of under \$500, *i.e.*, had probably less than 14 or 15 visits. Their charges constituted 10.7 percent of total charges. Some 26.5 percent had charges of \$500 to \$1,999 (about 14 to 57 visits), and their charges amounted to 25.0 percent of the total. Nine percent had charges over this period of \$2,000 to \$4,999, indicating about 57 to 143 visits over the three-year period. Their charges aggregated 26.2 percent of the total. Finally, 4.4 percent had charges of \$5,000 and over, indicating over 143 visits. The charges of this group constituted 38.1 percent of the total charges for all persons with supplemental charges for psychiatric care.

Table 26 compares utilization among the covered population in three areas: the District of Columbia, Maryland, and Virginia (as one area), Ohio, and California, and also in the United States as a whole. (The reason for this comparison was the plan's and the Civil Service Commission's concern about reported high utilization in the Washington, D.C., area.) The covered population in the District of Columbia, Maryland, and Virginia numbered 987,000 in 1973, or about 21 percent of the total population covered under the plan in its high option. Most of these persons were in the Washington, D.C., metropolitan area. The rate of utilization in the District

of Columbia, Maryland, and Virginia area was higher than in Ohio or California - 11.7 persons per 1,000 had supplemental physicians' charges for mental disorders, as compared with 5.5 in Ohio, 7.5 in California, and 6.3 in the United States as a whole. The average charge per person with charges was \$1,005 in the District of Columbia, Maryland, and Virginia as against \$497 in Ohio and \$794 in California. Relatively fewer persons in the District of Columbia, Maryland, and Virginia had charges of under \$500 than in Ohio and California—50.5 as against 79.5 and 61.3, respectively. On the other hand, the proportion of persons with charges of \$5,000 and over was higher in the District of Columbia, Maryland, and Virginia—3.0 percent with 19.3 percent of total charges, as compared with 2.1 with 26.8 percent of charges in Ohio, and 2.4 with 22.1 percent of total charges in California.

Table 27 also compares utilization in the District of Columbia, Maryland, and Virginia with that in Ohio, California, and the United States, but the data are for the three-year period 1971-73 inclusive. The data show that relatively more patients (7.4 percent) received long-term intensive therapy (\$5,000 and over) in the District of Columbia, Maryland, and Virginia area, and had 45.7 percent of total charges, compared with 2.7 percent of persons and 41.0 percent of charges in Ohio, 3.8 percent with 34.1 percent of charges in California, and 4.4 percent of persons and 38.1 percent of charges in the United States as a whole.

STUDY 2

COMPARISON OF BENEFITS FOR GENERAL AND MENTAL CONDITIONS UNDER EMPLOYEE HEALTH BENEFIT PLANS, 1974

Of 148 employee health benefit plans selected by the U.S. Bureau of Labor Statistics as constituting a rough cross-section of plans in American industry, 68 percent, as of August 1974, provided the same hospital benefits for mental conditions as for other conditions and 32 percent had reduced benefits for mental conditions. Forty-one percent of the plans provided the same outpatient (office) care of mental as of other conditions; 45 percent had reduced benefits for mental conditions; eight percent had no coverage for any condition; and five percent—all of which were negotiated by the United Auto Workers—provided greater benefits for mental than for general conditions; that is, they had no significant outpatient benefits for general conditions but did have some outpatient psychiatric benefits.

The Bureau of Labor Statistics* has, from time to time during the past 20 years, published a *Digest of Selected Health and Insurance Plans*. This provides summary information on the employee health benefit and insurance plans of some 140 to 150 large employers and/or unions in major industries. The companies and industries selected are chosen so as to constitute a rough cross-section of American industries: manufacturing, shipping, trucking, transportation, mining, utilities, banking, insurance, retail trade, service industries, etc. The companies selected include many of the giants of American industry: American Telephone and Telegraph, General Motors, General Electric, IBM, Exxon, American Airlines, U.S. Steel, Bethlehem Steel, Goodyear, etc. Some plans cover only hourly paid employees, some only salaried employees, and some cover all employees. Both negotiated and nonnegotiated plans are included.

Information on the provisions of these plans is obtained primarily through use of a questionnaire sent to the company or union whenever the BLS has obtained information to the effect that a significant change in the plan, e.g., negotiation of a new contract, has taken place.

The latest edition published is that for 1971, with supplements presenting more recent information issued in February and October 1973. A new edition¹ is to be published in 1975, and the office responsible generously allowed the writer to have access to the manuscript for this edition before it was sent to the printer. This edition presents information on the plans as of August 1974.

Data were selected on the duration of hospital care for general and mental conditions, and on the benefits for outpatient physicians' services (i.e., care in the office, home, or hospital outpatient department) for general and mental conditions. These data are presented in Table 1 at the end of this chapter. A summary column indicates whether the benefits for the two types of service were or were not the same for general and mental conditions.

As regards hospital care, 101, or 68.2 percent of the 148 plans, provided the same benefits for mental conditions as for general conditions. More specifically, there were 47 plans which, according to the information provided in the *Digest*, had a lower number of days for mental conditions than for general (nonmental) conditions, and 101 plans for which there was no specific mention of lower benefits for mental conditions. It is possible that the number of plans shown as having the same benefits for mental conditions is somewhat overstated, since some plans may have had special limitations on care for mental conditions but did not mention them because the BLS questionnaire did not specifically request such data.²

As regards physicians' outpatient care, the information provided in the *Digest* indicated that 61 plans—41.2 percent—provided the same benefits for mental as for general conditions, i.e., there was no mention of reduced benefits for mental conditions, and 12 plans provided no significant coverage for office or outpatient care of general and or mental conditions.³ Of the 75 plans

*The writer would like to express his appreciation of the assistance rendered to him by the personnel of the Division of General Compensation Structures, Bureau of Labor Statistics, and particularly Mr. Donald R. Bell, who has been directly responsible for the compilation of the *Digest*, and Mr. Donald M. Landay, Chief of the Division. Without such assistance this study could not have been done, or at any rate not nearly as well.

¹To be called *Digest of Health and Insurance Plans*.

²The questionnaires to be used in the future in compiling supplements to the new edition will specifically request data on outpatient mental health benefits.

³If a plan provided X-ray or laboratory diagnostic services as its only outpatient benefit, it was not considered as having outpatient coverage; if it provided electroshock treatment as its only outpatient benefit for mental conditions, it was not considered to have outpatient coverage.

which had different benefits for mental than for general conditions, 67 had reduced benefits and eight had greater benefits for mental conditions. All of the last were plans negotiated by the United Auto Workers (UAW) and all or most provided either no outpatient care for general conditions or none other than diagnostic X-ray and laboratory services, but did provide psychiatric benefits up to a specified maximum, generally \$400 a year. (Again, there is the possibility that the number of plans with lower benefits for mental conditions has been understated.)

In almost all plans—at least 90 percent—benefits for hospital care were provided under so-called basic benefits (as differentiated from the major medical type of benefits), *i.e.*, first-dollar coverage was provided for a stipulated number of days. In many plans such benefits provided a semiprivate room and full coverage of all ancillary services for the stipulated number of days. In other plans, per diem allowances were provided against room-and-board costs, and other allowances were provided against the costs of ancillary services. No note was taken of these provisions since in no case did it appear that these varied between general and mental conditions. The only variation seemed to be in the number of days covered.

Of the 47 plans which provided reduced benefits for hospital care of mental conditions, seven excluded care for mental conditions, although two or three of these provided coverage in cases of electroshock therapy or surgery, five provided 21 days (or 21 days in full plus nine additional days at 50 percent of the cost), 15 provided 30 days, nine gave 45 days, seven provided 60 or 70 days, and two provided 120 days. One plan provided 365 days, whereas the coverage for general conditions was 365 days for employees with less than a certain number of years of employment and 730 for those with a longer period of service. Another plan provided unlimited benefits for mental conditions treated in general hospitals, but limited care in mental hospitals to 60 days a year. It is plain that some of the plans with reduced benefits nevertheless provided substantial coverage.

No data were selected regarding coverage of in-hospital physicians' visits for general and mental conditions for two reasons: most plans provided such benefits under basic benefits and in only a handful of plans—certainly less than ten—was any difference, *i.e.*, a lower number of visits for mental conditions, noted. Secondly, provisions on in-hospital physicians' benefits are sometimes quite detailed, and dealing with such provisions would have so extended the mass of data dealt with as to be impractical in a summary tabulation. Where some special limit on in-hospital visits for mental conditions was noted, the effect was to limit the visit days for mental conditions to the same number of days that were covered for hospital care. It should be borne in mind that a limitation on number of days of hospital care for mental conditions is in effect a limitation on physicians' visits for mental conditions. In the case of plans which

provided benefits for in-hospital physicians' visits through a major medical approach, only one was noted as having any special limitation on in-hospital physicians' care for mental conditions.

The main coverage of outpatient care for mental conditions—generally the only coverage of consequence—was under major medical provisions, *i.e.*, where the plan paid 80 percent (in a few cases 75 or 85 percent) of charges in excess of a stipulated deductible—generally \$50 or \$100—and up to a specified maximum in benefit payments. Where there were reduced benefits for mental conditions (*i.e.*, psychiatric care), they were usually in the form of the plan's paying only 50 percent of charges instead of the higher percentage paid for general conditions. In a fair number of cases of reduced benefits, the reduction might be made by imposing so-called inside limits, *i.e.*, covering charges of no more than, say, \$20 or \$30 a visit for no more than a stipulated number of visits per year, or more commonly simply a lower overall dollar limit of benefits payable for outpatient psychiatric care. In some cases, such limits might be imposed, together with a lower percentage of charges paid.

More precisely, of the 67 plans with reduced coverage of outpatient care for mental conditions, 23 plans reduced the percent of charges paid from 80 to 50 percent with no other restriction or limitation. Some 15 plans made the reduction by setting a special lower maximum on benefits for psychiatric care—in some cases this maximum may be only a few hundred dollars, in other cases several thousand dollars. Seven plans paid only 50 percent of charges and also imposed a special limit on psychiatric benefits. Another nine paid 50 percent and had inside limitations on number of visits, amount of reimbursable charges per visit, or both; another four had inside limits of this type only. A few plans—three—paid 80 percent of charges up to a given maximum and then lowered the percentage paid. Two paid less than 80 percent of charges but more than 50 percent. The remainder had other provisions. Included was one that paid 100 percent of psychiatric charges up to a given amount and then dropped the percentage to 80, but which, overall, still had lower benefits for psychiatric than for other conditions.

All of the above reductions apply only to outpatient physicians' services for mental conditions. It is important to state that only one plan (the writer recalls) with major medical provisions reduced the proportion of charges payable or imposed any other special restriction on physicians' care for mental conditions while in the hospital.

While the above noted major medical provisions are the main method of providing benefits for outpatient care for mental conditions, some 33 plans (some of which also had major medical coverage) had so-called basic benefits for physicians' office visits. These plans paid a stipulated allowance—perhaps \$3, \$5, or \$7—for each office visit up to a certain number of visits or certain amount of benefits per year. In no case was there any mention of reduced benefits for psychiatric care.

Probably no reduction was thought necessary for deterrence of utilization, since the difference between the scheduled allowance and the usual fee for psychiatric office care would be such as to impose a barrier to utilization.

A caveat on the validity of these findings is in order. These data represent all the information on benefits for mental conditions that were in the Bureau of Labor Statistics files on these plans, and the unit responsible for the *Digest* made a special complete review of its data on all plans so as to assure that the information reported here and in the forthcoming *Digest* would represent an accurate statement.

However, it is possible that the data do understate, hopefully to only a slight extent, the number of plans with special limitations on hospital or outpatient coverage of mental conditions.

One possible source of understatement is that, as already mentioned, the main source of information provided to the BLS on these plans is the questionnaire sent out to the employer or union when the BLS learns that a change in the plan has occurred. The questionnaire gives a summary of the old plan and asks the employer or union to indicate any changes. The persons who compiled the *Digest* have been concerned primarily with benefits for general conditions. If, in the past, special limitations on benefits for mental conditions were not noted and hence did not appear on the questionnaire, it is possible that the employer or union, in completing the questionnaire, might not note the limitations on mental benefits, since there was no change in the plan in this respect and the questionnaire did not specifically ask for benefits for mental conditions.

An important qualification is that the data on hospital benefits pertain only to care in general hospitals. The BLS does not note limitations on care in mental hospitals. Probably 40 to 50 percent of all plans had Blue Cross-Blue Shield plans as the carrier for hospital care.⁴

The majority of the Blue Cross plans, under their local contracts, provide fewer days of hospital care for mental conditions in general hospitals than for general conditions, the great majority provide fewer days for mental conditions in mental hospitals than in general hospitals, and some plans entirely exclude care in mental hospitals.⁵ The BLS has not noted these limitations on care in mental hospitals. (However, there is some indication from Study 5 that Blue Cross plans under national accounts, i.e., serving employers in more than one state, tend to provide the same number of days for mental conditions, irrespective of type of hospital.) Insurance companies generally provide the same hospital benefits for mental as for general conditions under their group contracts, irrespective of type of hospital.

In conclusion, an examination of a rough cross-section of employee health benefit plans in American industry indicates that almost all plans (95 percent) have some coverage of hospital care for mental conditions and that about two thirds have the same hospital coverage for mental conditions in general hospitals as for general conditions. About 92 percent of the plans have some coverage of physicians' outpatient (office) care of general and/or mental conditions. Of the plans with some outpatient coverage, 45 percent have the same coverage for mental as for other conditions, 49 percent have reduced benefits for mental conditions, and six percent have greater outpatient benefits for mental than for other conditions.

Many of the plans that have lower benefits for mental conditions than for other conditions, either for hospital care or physicians' care in the office, nevertheless have significant benefits for mental conditions.

Finances and Enrollment," *Social Security Bulletin*, March 1974, and the *Blue Cross and Blue Shield Fact Book*, 1973. Blue Cross Association and National Association of Blue Shield Plans.)

⁵L. S. Reed, E. S. Myers, and P. L. Scheidemandel: *op. cit.*, p. 46. A more recent study found that as of November 1974, of the 74 Blue Cross plans, 52, under their most widely held contract, provided lower benefits for mental illness in general hospitals than for general illness and all but six provided lower benefits in mental hospitals. See Study 3 of this volume.

⁴In 1972, of all persons having group coverage for hospital care through either Blue Cross-Blue Shield or insurance companies, approximately 43 percent had Blue Cross-Blue Shield coverage. (M. S. Mueller: "Private Health Insurance in 1972: Health Care Services.

TABLE I

Comparison of Benefits for General and Mental Conditions Under Selected Health Plans, 1974

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Aluminum Co. of Am. Steelworkers All employees	365-730	120	80% of charges over ded. \$50 up to \$10,000 per year	Same	No	Yes
American Airlines All employees	100% 1st \$1,000; then 80% of excess	Same	80% of charges over ded. \$50 up to \$20,000 lifetime	50%	Yes	No
American Can Co. Steelworkers	365-730	Same	80% of charges over ded. \$50 up to \$10,000 per year	Limited to \$400 per year	Yes	No
American Seating Co. Auto workers All prod. employees	365	45	\$3 per visit up to \$225	Same	No	Yes
American Standard, Inc. Plumbing & Heating Div. All prod. employees	365	Same	None	None	Yes	No coverage
Amer. Tel. & Tel. Co. Communication workers All regular employees	120	30	80% over ded. (2% of annual pay), no limit	50% or same if absent from work	No	No
Amstar Corp., Brooklyn Refinery Longshoremen's Union (I.L.A.) Local 9	70 plus 50% of cost for additional 180	30	\$7 per visit to \$2,555 year; 80% over ded. \$100 up to \$10,000 per disability	Same	No	Yes
Armour & Co. Meat cutters union All prod. employees	365	Same	80% over ded. \$300 up to \$15,000 per disability	Same	Yes	Yes
Armstrong Cork Co. Rubber workers All employees	365	Same	80% over ded. \$100 up to \$20,000 per disability	Same	Yes	Yes
Bethlehem Steel Corp. Steelworkers Union Hourly paid employees	365-730	60	80% over ded. \$50 up to \$15,000 per year	80% up to \$1,500 per year	No	No
Borden, Inc. Salaried employees	120	70	80% over ded. \$100 up to \$25,000 lifetime	50% up to \$2,500 per year*	No	No
Brewers Board of Trade (NYC) Teamsters	120 plus 50% for additional 180 days	None except for shock therapy or surgery	80% of first \$5,000 over ded. \$50; 100% of excess up to \$10,000 per disability. HIP or GHI optional	Same	No	Yes
Building Service Welfare Fund (NYC) Service employees	21 plus 50% for additional 180 days	Excluded except for electroshock or surgery	80% over ded. \$100 up to \$5,000 lifetime	Same	No	Yes
Burlington Industries, Inc. Nonunion salaried employees	100% 1st \$1,000 85% of excess	Same	85% over ded. \$75 up to \$30,000 lifetime	Same	Yes	Yes
California Metal Trades Assn. Various unions	100	Same	\$6 per office visit up to 100 visits; 80% over ded. \$50 up to \$10,000 lifetime	Same	Yes	Yes

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Campbell Soup Co. Meat cutters Hourly employees	120	Same	\$4 per visit up to \$186 per 6-month period; 80% over ded. \$50 up to \$20,000 per disability	50%	Yes	No
Campbell Soup Co. Salaried employees	120	Same	80% over ded. \$50, no limit	Same	Yes	Yes
Caterpillar Tractor Co. Auto workers Hourly employees	365	120	None except diag. X-ray and laboratory	Benefits up to \$1,000 per yr.	No	No (Mental greater)
Caterpillar Tractor Co. Exempt sal. employees	Unlimited	Same	80% over ded. \$80 up to \$50,000 per year	80% 1st \$500; thereafter 50%	Yes	No
Chase Copper and Brass Co. Metal Works & Forging Div. Auto workers	365	Same	\$2 per visit	Same	Yes	Yes
Chase Manhattan Bank, Nat'l. Association All employees	120 plus 50% for additional 180	21 plus 9 at 50%	80% over ded. \$100 up to \$50,000 lifetime	30 doctor visits up to \$214.50 maximum; * same except not covered until coverage in effect for 2 years	No	No
Chicago Transit Auth. Transit union All employees	120	Same	80% over ded. \$100 up to \$15,000 lifetime	50% up to maximum of \$20 per visit, 50 visits per year	Yes	No
Clothing Industry Men and boys clothing Clothing workers national plan	120	Same	None except care in Union health centers	Same	Yes	Yes
Cuett, Peabody and Co., Inc. Salaried and nonunion hourly employees	60	Same	\$5 per visit; 80% over ded. \$100 up to \$25,000 per year; \$50,000 lifetime	\$5 per visit; 80% up to \$10,000 p/yr. and \$20,000 lifetime	Yes	No
Coal Industry Mine workers	Unlimited	Same	Full cost of care by specialists	Same	Yes	Yes
Cone Mills Corp. Textile workers (TWU-A)	70	Same	80% over ded. \$100 up to \$20,000 lifetime	Same	Yes	Yes
Consolidated Foods Corp. Nonunion salaried employees	80% of charges up to \$20,000 lifetime	Same	80% over ded. \$100 up to \$20,000 lifetime	Same	Yes	Yes
Construction Industry, Assoc. General Contractors of America (N. Cal.) Carpenters	70; KHF Plan optional	Same	\$4 per visit up to \$300; 80% over ded. \$40 up to \$10,000 per year. KHF Plan optional	Same	Yes	Yes
Construction Industry Various employers (NYC) Carpenters	365	Same	\$5 per visit up to \$300	Same	Yes	Yes
Construction Industry Various employers (NYC) Painters	120 plus 50% for additional 180 days	None	Benefits of either HIP or GHI	Probably less	No	No

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Continental Can Co., Inc. Paper operations Paper workers	120	Same	80% over ded. \$50 up to \$20,000 lifetime	Same	Yes	Yes
Continental Can Co. Steelworkers	365-730	Same	80% over ded. \$50 up to \$10,000 per year	Up to \$400 in benefits in 12-month period	Yes	No
Crown Zellerbach Corp. Nonunion Salaried employees	Unlimited	Same	80% over ded. \$50 up to \$4,000; then 100% up to \$250,000	Same, but 50%	Yes	No
Deere and Co. Auto workers	365	45	\$2 per visit up to \$350 per disability	Psychiatric care up to \$400 per calendar year	No	No (Mental greater)
Detroit Edison Co. Utility workers All employees	365	Same	80% over ded.; \$100 up to \$25,000	Psychiatric care: 80% 1st \$100; 70% 2nd \$100; 60% next \$100; 50% of excess up to \$3,000	Yes	No
Distillery Industry Various employers Distillery workers	365	Same	\$8 per visit; 80% over ded. \$50 up to \$20,000 lifetime	Same	Yes	Yes
Nat'l. Assn. of Doll Importers and Stuffed Toy Mfrs. Assn. (NYC) Toy & novelty workers	21 plus 50% for additional 40 days	None except for shock therapy or surgery	80% over ded. \$100 up to \$20,000 per disability	Same	No	Yes
Dow Chemical Co. Midland Div. Steelworkers	365	45	None	Psychiatric care, \$400 per year; psychological testing, \$38.25	No	No (Mental greater)
Dress Industry, Affiliated Dress Mfrs. (NYC) Ladies garment workers	120 plus 50% for additional 180 days	30	\$6 for 1st visit, \$5 for additional visits; 80% over ded. \$100 up to \$10,000 per year	\$12.50 per visit or 50% of charges, whichever is less, up to maximum of \$250 per 12 months	No	No
Retail Drug Industry Various employers (NYC) Drug & hosp. union	120 plus 50% for additional 180 days	21	\$8 per visit, 80% over ded. \$50 up to \$100,000 lifetime	Limited to 50 visits	No	No
E. I. du Pont de Nemours and Co. All employees	120	Same	80% over ded. \$100 up to \$50,000 lifetime	50% of charges	Yes	No
Eastman Kodak Co. All employees	120	Same	80% over ded. \$100 up to \$100,000 lifetime	Up to \$1,200 per calendar year	Yes	No
E-Systems, Inc. Meipar Div. All employees	31	Same	80% over ded. \$100 up to \$10,000 per disability	Psychiatric expenses not covered (except as a result of organic disorder)	Yes	No
Exxon Corp. All employees	120 plus 50% for additional 180 days	30	80% over ded. of 2% of earnings (max. \$150) up to \$100,000 lifetime	Same except up to \$25 per visit	No	No
Firestone Tire and Rubber Co. Rubber workers	730	Same	80% over ded. \$100 up to \$25,000 per year	50%	Yes	No

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
FMC Corp. American Viscose Div. Textile workers (TWUA)	365	Same	80% over ded. of \$100 of 1st \$2,000; then 100% up to \$20,000 per disability	Same	Yes	Yes
Retail Food Industry Food Employers Council (S. Cal.) Retail Clerks	120	70	\$7 per visit up to \$350; 80% over ded. \$50 up to \$20,000 lifetime	Up to maximum of \$1,500	No	No
Ford Motor Co. Automobile workers	365	45	None except X-ray and laboratory	Psychiatric services up to \$400 per year	No	No (Mental greater)
Fur Manuf. and Retail Industries, Associated Fur Mfrs. (NYC) Meat cutters	120 plus 50% for additional 180	21 plus 9 at 50%	\$5 per visit, no limit, 75% over ded. \$100 up to \$10,000 lifetime, HIP optional	Same	No	Yes
Furniture Industry Various employers Furniture workers	201	21 plus 50% for 9 additional days	\$7 per visit up to \$500; 80% over ded. \$50 up to \$10,000 lifetime	50%, \$10 per visit for up to 50 visits per year	No	No
Industrial Relations Council of Furniture Mfrs. in S. Cal. Carpenters	120	None	Complete care in Union Clinic; 80% up to \$10,000 lifetime	Same	No	Yes
General Electric Co. Electrical workers (IUE) and other unions All employees	365	Same	85% over ded. \$50 up to \$250,000 lifetime	50%	Yes	No
General Foods Corp. Various unions	120 plus 50% of cost for additional 180 days	Same	75% over ded. \$200 up to \$10,000 per year	50%	Yes	No
General Motors Corp. Automobile workers	365	45	None except X-ray and laboratory	Psychiatric services up to \$400 per year	No	No (Mental greater)
General Motors Corp. Salaried employees	365	45	80% of 1st \$2,500 over ded. \$100; thereafter 100% up to \$25,000 per yr.	100% of 1st \$400; then 80% up to \$25,000	No	No
Gimbel Brothers, Inc. Salaried employees and those rep. by Service Employees Union	21 plus 50% of cost for additional 180 days	30	80% over ded. \$100 up to \$20,000 lifetime	50% with limits of \$10 per visit up to \$500 per year	No	No
B. F. Goodrich Co. Rubber workers	730	Same	None except X-ray	None**	Yes	No coverage
Goodyear Tire and Rubber Co. Salaried employees	730	Same	80% over ded. \$100 up to \$25,000 per disability	50%; limit of \$30 per visit for 50 visits per year	Yes	No
The Greyhound Corp. Salaried employees	70	Same	80% over ded. \$75 up to \$5,000 per year	50%	Yes	No
Hart, Schaffner and Marx All nonunion employees	31	Same	80% over ded. \$100 up to \$20,000 per disability	Same	Yes	Yes

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Honeywell, Inc. (Minneapolis, Minn.) Teamsters, Local 1145	365	Same	80% over ded. of 2% of pay (\$100-300) up to \$50,000 per disability	Same	Yes	Yes
Affiliated Hospitals of San Francisco Service employees	70 (\$25 deductible)	Same	\$5 per visit up to \$350; 80% over ded. \$100 up to \$10,000 lifetime	Same	Yes	Yes
Affiliated Hospitals of San Francisco California Nurses Assn.	70 (\$25 deductible)	Same	\$5 per visit up to \$350; 80% over ded. \$100 up to \$10,000 lifetime	Same	Yes	Yes
Hotel Assoc. of NYC N.Y. Hotel and Motel Trades Council	21 plus 50% for additional 180 days	None except for shock therapy or surgery	Benefits (comprehensive care) at industry-union health center	Same	No	Yes
Industrial Employers and Distributors Assn. (N. Cal.) Longshoremen (ILWU)	70	Same	\$7 per visit; 80% over ded. \$100 up to \$20,000 any 5 consecutive years	\$20 per visit for up to 50 visits	Yes	No
Interco, Inc. Executive and adminis. employees	100% of 1st \$225 in excess of \$25, then 80% up to \$10,000 a year	Same	80% over ded. \$50-\$100 up to \$10,000 in calendar year	50%	Yes	No
Interco, Inc., Florsheim Div. Shoe workers	60	Same	80% over ded. \$100 up to \$10,000 lifetime	50%	Yes	No
Interco, Inc. International Shoe Co. Shoe workers	31	Same	None	None	Yes	No coverage
International Business Machines Corp. All regular employees	365	Same	80% over ded. \$150 up to \$100,000 lifetime	Up to \$15,000 lifetime	Yes	No
International Harvester Co. Auto workers	365	Same	None except X-ray and laboratory	Psychiatric benefits up to \$400 per year	Yes	No (Mental coverage better!)
International Harvester Co. Managerial salaried employees	365	Same	80% over ded. \$100 up to \$25,000 lifetime	Same	Yes	Yes
International Paper Co. Northern Division Paper workers	70	Same	80% over ded. \$100 up to \$10,000 per year	50%	Yes	No
International Paper Co. Northern Division All salaried employees	120	Same	80% over ded. \$100 up to \$10,000 per year	Same	Yes	Yes
Jewelry Mfrs. Assn. (NYC) Jewelry workers, Local #1	50 plus 50% of cost for additional 180	30	\$4 per visit up to \$150; 80% over ded. \$50 up to \$25,000	Same	No	Yes

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Johnson and Johnson (New Brunswick, N.J.) Textile workers (TWUA)	730	Same	None	Same	Yes	No coverage
Kennecott Copper Co. Steelworkers Production employees	365	Same	1 visit per day at R&C charge; 90% over ded. of \$100, no maximum	Same	Yes	Yes
S. S. Kresge Co. All full-time workers in Detroit area	365	70	None except X-ray and laboratory	None	No	No coverage
Kroehler Mfg. Co. Nonunion salaried employees	70	Same	80% over ded, \$100 up to \$25,000 lifetime	50%	Yes	No
Laundry Industry Various employers (NYC) Clothing Workers	60	Same	Care in union health center	Same	Yes	Yes
Lerner Stores Corp. All salaried employees	120	Same	80% over ded, \$100 up to \$25,000 per disability	Same*	Yes	Yes
Lever Brothers Co. Chemical workers; Oil, Chemical and Atomic workers—all permanent employees	120 plus \$5 a day for additional 245	Same	80% of 1st \$3,125 over ded, \$100; then 100% of next \$17,500	50%	Yes	No
LTV Aerospace Corp. Vought Aeronautics Co.; Texas Div., Auto workers	365	45	None except X-ray and laboratory	Psychiatric services in outpatient facility up to \$400 per family per year	No	No (Mental greater)
Luggage and Leather Goods, Ind. Leather Goods, Plastic and Novelty Workers	31	Same	None	Same	Yes	No coverage
Lumber Industry Various employers (So. Cal.)—Carpenters	100	Same	\$6 per visit up to \$300 per 6 months; 80% over ded, \$100 up to \$50,000 in any 5-year period	Same	Yes	Yes
Maritime Industry Various employers (Atlantic & Gulf Coasts) Marine engineers	70	Same	\$7 per visit, 1 per day, no limit; 80% over ded, \$100, no limit	Same	Yes	Yes
Maritime Industry Various employers (Atlantic & Gulf Coasts) Maritime Union	120	Same	80% over ded, \$100 up to \$10,000 lifetime	Same	Yes	Yes
Maritime Industry Various employers (Atlantic & Gulf Coasts) Seafarers	Unlimited	Same	None except diagnostic services at union health centers	Same	Yes	No coverage
Massachusetts Leather Mfrs. Association Leather workers	Unlimited	Same but 60 in mental hospitals	Office visits, full cost, no limit; 80% over ded, \$25 per quarter, up to \$50,000 lifetime	Psychiatric care: \$300/year***	No	No

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
McCrory Corp. McCrory-McLellan-Green Stores Division Nonunion salaried employees	120	30	80% over ded. \$100 up to \$25,000 per year	Same*	No	Yes
McDonnell Corp. All salaried employees	365	Same	80% over ded. of \$25 or \$50, up to \$50,000 lifetime	1st 5 visits 100% of sched. allowance, 6th to 10th visit, 85%; 11th to 15th visit, 70%; then 55% max. benefit \$400/year	Yes	No
Metalworking (Manufac- turing and repair services) Various employers (St. Louis, Mo.)— Machinists	50	Same	80% over ded. \$100 up to \$10,000 lifetime	1 visit per day, 50 per year	Yes	No
Metropolitan Taxicab Board of Trade (NYC) Taxi Drivers Union	120	30	\$4 per visit up to \$500; HIP and GHI optional	Same*	No	Yes
Metropolitan Transit Comm., Transit Operating Division (Minneapolis, Minn.) Transit Union, Local 1005	31	Same	80% over ded. \$100 of 1st \$2,000, then 100%, up to \$25,000 per disability	50% of 1st \$2,000, 100% of excess	Yes	No
Milk Dealers Various employers (Chicago, Ill. area) Teamsters Local 753	40	Same	80% over ded. \$200 up to \$5,000 per disability	Same	Yes	Yes
Millinery Industry Amer. Millinery Mfrs. Assn. (NYC) Hatters, cap and millinery workers	31	Same	X-ray and laboratory only	Same*	Yes	No coverage
Minnesota Mining & Manuf. Co. Oil, chemical and atomic workers	100% of 1st \$750 and 85% of excess, \$25,000 maximum	Same	85% over ded. \$40 up to \$25,000 lifetime	60%, maximum \$500 per year	Yes	No
Mobil Oil Corp. Various unions	100% for 1st 120 days, then 80%	Same	80% over ded. \$50 to \$200 depending on pay, up to \$25,000- \$50,000 lifetime	50%	Yes	No
Nabisco, Inc. Bakery and Confectionery Workers	70	Same	80% over ded. \$100 up to \$10,000 per disability	Same	Yes	Yes
National Auto. Transporters Association Teamsters	Unlimited	Same	80% over ded. of \$100 up to \$7,500 per disability	Same	Yes	Yes
National Steel Corp. Western Steel Division Independent steel- workers All hourly employees	365-730	365	80% over ded. \$50 up to \$10,000 per year; \$20,000 per disability	Same	No	Yes

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
New York Shipping Assoc. Inc. Longshoremen (ILA) All employees covered by agreement	70 days—Plan A Unlimited—Plan B	Same	80%, no ded. up to \$20,000 per disability or Plan B services at NYSA-ILA Medical Center and 100% other services	Same	Yes	Yes
The New York Times Co. Newspaper Guild All salaried employees in bargaining unit	120	30	75% over ded. of \$100 up to \$20,000 lifetime	Same*	No	Yes
Northwest Forest Products Association (Cal., Oreg., Wash., Mont.) Woodworkers	180—employees 70—dependents	Same	Full cost for unlimited visits, dependents 35 visits	Same	Yes	Yes
Owens-Illinois, Inc. Glass Bottle Blowers Hourly employees	70	Same	80% over ded. \$50 up to \$20,000 lifetime	50%	Yes	No
Pacific Gas and Electric Co. All regular employees	365	Same	Full cost (Reasonable and customary charge for up to 100 visits per year); KHF plan optional	Same	Yes	Yes
Pacific Maritime Assn. Longshoremen's (ILWU) Longshoremen, ship clerks and walking bosses	70—employees 35—dependents KHF plan optional	Same	\$5 per visit, unlimited; 100% over ded. \$250 up to \$700 per disability; KHF plan optional	Same	Yes	Yes
Penn Central Transp. Co. Employees not covered by bargaining agreement	180	Same	\$6 per visit up to 180 visits; 80% over ded. \$100-\$250 up to \$50,000 lifetime	Same	Yes	Yes
Pennsylvania Power and Light Co. All full-time employees	120	30	Up to 21 visits at reasonable and customary charge; 80% over ded. \$100 up to \$25,000 per disability	Same; 50% and maximum of \$250	No	No
Personal Services Industry Barber shops Various employers (Detroit, Mich.) Barbers Guild 4 & Local 552	365	45	None except X-ray and laboratory	Same	No	No coverage
Pfizer, Inc. All nonunion employees	365	Same	80% over ded. \$100 up to \$100,000 lifetime	Up to \$25,000 lifetime	Yes	No
Philip Morris, Inc. Tobacco workers	120	Same	80% over ded. \$50 up to \$20,000 lifetime	50%	Yes	No
PPG Industries, Inc. Glass and ceramic workers	365	45	None	Psychiatric care up to \$400 per year	No	No (Mental greater)
PPG Industry, Inc. Nonunion salaried employees	100% first \$2,000; 80% of excess	Same	80% over ded. \$100 up to \$100,000 lifetime	50%; maximum \$20 per visit	Yes	No

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Printing Industry Brown and Bigelow and other employers— Bookbinders	70	Same	None except X-ray and laboratory	Same	Yes	No coverage
Printing Industry Chicago Lithographers Association— Lithographers	31	Same	\$3 per visit up to \$200; 80% over ded. \$100 up to \$30,000 lifetime	50%	Yes	No
Prudential Insurance Co. of America All employees	100% of 1st \$5,000; 80% of excess	Same	80% over ded. \$50-\$250, unlimited	50%; maximum \$40 per visit, 50 visits	Yes	No
Publishers' Assoc. of NYC Typographers, Local 6	365	Same	\$6.50 per visit, no limit; HIP and GHI optional	Same	Yes	Yes
Pullman, Inc. Pullman-Standard Div. Steelworkers	365-730	60 per year	80% over ded. \$50 up to \$15,000 per year	Up to \$1,500 per year	No	No
Railroad Industry Various employers Various unions	365	Same	\$6 per visit up to \$1,350 per year; 80% over ded. \$100 up to \$50,000 lifetime	65%	Yes	No
RCA Corporation Electrical (IUE and IBEW) All employees	365 plus 80% for all additional days	Same	80% over ded. \$100 up to \$100,000 per disability	50%, limits of \$20 per visit, 100 visits per benefit period (2 years per disability)	Yes	No
Restaurant Industry Various employers (NYC) Hotel & restaurant employees, Local 89	120 plus 50% of cost for additional 180	None except for shock or surgery	Benefits of HIP or GHI	Both offer reduced benefits for mental conditions	No	No
Retail Trade Industry Various employers (NYC) Retail clerks, Local 888	31	Same	80% over ded. \$100 up to \$10,000 per disability	Same	Yes	Yes
Retail, Wholesale and Warehouse Industries Various employers (NYC) Retail, Wholesale and Department Store Union—District 65	120 plus 50% for additional 180	21 plus 9 at 50%	Visits at regular and customary charge, no limit	Same	No	Yes
Rockwell Intern'l. Corp. Auto workers All employees	365	Same	80% over ded. \$50 up to \$7,500 per year (hourly); \$20,000/year for others	Psychiatric up to \$400	Yes	No
Safeway Stores, Inc. All full-time salaried and wage employees	70	Same	\$4 per visit up to \$150; 80% over ded. \$100 up to \$15,000 per disability	50%	Yes	No

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Shipyards Industry Various employers (Pacific Coast) Various metal trades unions	70—employees 31—dependents	Same	\$5.50 per visit, 100 visits; 80% over ded. \$100 up to \$10,000 lifetime	Same	Yes	Yes
Sperry Rand Corp. Sperry Gyroscope Div. and Sperry Systems Mgt. Div. Electrical (IUE)	120 plus 50% of cost for additional 180	30 per year	80% over ded. \$100 up to \$10,000 per benefit period; HIP and GHI optional	Same	No	Yes
Sperry Rand (same as above) All nonunion salaried employees	120 plus 50% for additional 180	30 per year	80% over ded. \$100 up to \$25,000 per benefit period	Same	No	Yes
Standard Oil Co. (Ind.) and subdivision All employees	100% of 1st \$500 of room and 1st \$3,975 of ancillaries, then 75% up to \$25,000 a year	Same	75% over ded. \$100 up to \$25,000 per year	50%	Yes	No
J. P. Stevens and Co. Inc. All regular full-time salaried employees	365	Same	80% over ded. \$150 up to \$25,000 per calendar year	50%	Yes	No
Susquehanna Corp. Atlantic Research Corp. Division Salaried employees	180	30	80% over ded. \$100 up to \$10,000 lifetime	Same	No	Yes
Swift and Co. (Esmark, parent co.) Meat cutters	365	Same	80% over ded. \$300 up to \$5,000 per disability	Same	Yes	Yes
Swift and Co. (Esmark, parent co.) Salaried employees	365	Same	80% over ded. \$100 up to \$20,000 lifetime	\$20 a visit, 40 visits per year	Yes	No
Time, Inc. All salaried employees	365	30	75% over ded. \$50 up to \$50,000 lifetime	Same	No	Yes
Trucking Industry Local cartage & over-the-road freight, various associations and employers—(Central States, Southeast & Southwest areas) Teamsters	Unlimited	Same	80% over ded. \$100 up to \$7,500 per disability	None	Yes	No
Trucking—Warehouse & other industries (Western States)— Teamsters (Western Confer.)	70	Same	\$5 per visit up to \$750; 80% over ded. \$100 up to \$25,000 lifetime	50% up to \$15,000	Yes	No
TRW, Inc. All salaried employees in Cleveland, Ohio, area	730	Same	80% over ded. \$25 up to \$10,000 per year	Same*	Yes	Yes
Union Carbide Corp. Salaried employees in NYC and Westchester County	120	30	80% over ded. \$100 up to \$20,000 lifetime	Same	No	Yes

TABLE 1 (Continued)

Company	Hospital care		Outpatient physicians' services		Benefit is same for both types of conditions (Yes or No)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Uniroyal, Inc. Rubber Workers	730	Same	None except X-ray allowance	Same	Yes	No coverage
United Airlines, Inc. Machinists, all employees	365	Same	80% over ded. \$100-\$300 (dep. on pay) up to \$200,000 per disability	Same	Yes	Yes
United States Lines, Inc. All salaried employees	31	Same	80% over ded. \$50-\$100 up to \$10,000 per disability	50% up to \$20 a visit, 75 visits/year	Yes	No
United States Steel Corp. Steelworkers Hourly paid employees and nonexempt salaried employees	365-730	60 days per 12-month period	80% over ded. \$50 up to \$15,000 a year	\$1,500 per year	No	No
United States Steel Corp. Exempt salaried employees	730	70	80% over ded. \$50 of 1st \$2,000, 90% of excess up to \$20,000 per year	Same but 80% of 1st \$1,000 and 50% of excess per calendar year up to \$20,000	No	No
Upholstering and Allied Trades Industries Various employers Upholsterers	50—employees 31—dependents	Same	\$2 per visit of up to \$150; 80% over ded. \$100 up to \$10,000 lifetime	50%; \$20 per treatment, 1 per week	Yes	No
Westinghouse Electric Corp. Electrical (IUE) All employees	365	Same	85% over ded. \$50 up to \$250,000 lifetime	50%	Yes	No
Westvaco Corp. Paper workers All hourly union employees	70	Same	80% over ded. \$100 up to \$15,000 per benefit period	50%	Yes	No
Weyerhaeuser Co. Nonunion salaried employees	100% 1st \$1,200, 80% of excess up to \$30,000 lifetime	Same*	80% over ded. \$50 up to \$30,000 lifetime	Same but up to \$20 per visit, \$500 per calendar year	Yes	No
Wyandotte Industries Corp. Div. of First Hartford Textile workers (TWUA)	70	Same	None	Same	Yes	No coverage

* Under basic benefits, allowances for electroshock treatments in or out of hospital.

** Allowances for electroshock treatments in or out of hospital.

*** Under basic benefits, full cost of electroshock treatments in or out of hospital.

STUDY 3

BLUE CROSS HOSPITAL BENEFITS FOR MENTAL ILLNESS*

Most Blue Cross plans provide lower benefits for mental conditions than for general, *i.e.*, nonmental, conditions. As of November 1974, 52 of the 74 plans—70 percent—under their most widely held contract¹ provided lower benefits for mental illness cared for in general hospitals than for general illness, while 22—30 percent—had the same benefits for both general and mental conditions in general hospitals.² The situation under the most comprehensive contract of the plans was the same. Only six plans under both their most widely held and most comprehensive contracts provided the same benefits for mental as for general conditions in both general and private mental hospitals, and only three or four of these provided the same benefits for mental as for general conditions in general hospitals and in both private and public mental hospitals.

However, to accentuate the positive side of the situation, all except four Blue Cross plans provided some coverage of care for mental illness in general hospitals under their most widely held contract, and the four that were the exception offered riders, at an additional premium, giving such coverage. Furthermore, 52 plans—70 percent—under the most widely held contract provided some coverage of mental conditions in private mental hospitals, and 34 provided some coverage of care in public mental hospitals. A few other plans offered this coverage under their most comprehensive contract.

The accompanying compilation, "Blue Cross Plans: Duration of Benefits for General and Mental Illness and Tuberculosis" (see Table 7 at the end of this chapter), includes the number of benefit days provided by each plan for general illness and for mental illness in general hospitals and in private and public mental hospitals, as of November 1974. The data were compiled by the Blue Cross Association from the *Blue Cross Manual*, an in-house publication, which describes the contracts issued by each plan.

*The writer would like to express his thanks to the Blue Cross Association and particularly to Mr. Joseph C. Woosley, Senior Vice President, Research and Development, and his staff for their assistance, without which this study could not have been made.

¹The most widely held contract of a plan is the contract held by more members than any other contract. It is not necessarily the contract held by a majority of the members.

Tables 1 and 2, developed from this compilation, show the distribution of plans according to number of benefit days for general illness and for mental illness in general hospitals and in public and private mental hospitals. Under their most widely held contract (Table 1), all except five of the 74 plans provided 70 or more days of care per admission for general illness, and almost three fourths provided 120–125 or more days per admis-

TABLE 1
Duration of Benefits for General and Mental Illness
Under Most Widely Held Contract
Blue Cross Plans, November 1974

Days of care provided	General illness in		Mental illness in		
	General hospitals	General hospitals	Private mental hospitals	Public mental hospitals	
All plans	74	74	74	74	
Zero	—	4 ^a	22 ^c	40 ^c	
10	—	1	1	1	
15	—	1	—	—	
20-21	1 ^e	2	1	1	
30-31	4	42 ^b	33 ^d	22 ^d	
35	—	—	—	—	
45	—	1	2	2	
70	12	5	6	1	
90-100	2	1	—	—	
120-125	39	12	8	6	
150-180	2	—	—	—	
365	13	5	1	1	
485	1	—	—	—	
730	—	—	—	—	

^aAll of these offer riders covering care for 30 or more days.

^bThree of these plans offer riders to increase days to 70, 90, or 120.

^cTwo of these plans offer riders covering care for 30 days or more.

^dOne offers a rider to increase coverage to 70 or more days.

^eProvides an additional 180 days at half benefits.

Note: A few of the plans shown as providing benefits in private mental hospitals provide such benefits in member or contracting hospitals only and few or no mental hospitals may be in this category. Also some plans, about nine, limit benefits to very small allowances per day, *e.g.*, \$9, \$10, \$15, \$16, \$18 per day, while a number of others provide reduced benefits as compared with those provided for stays in general hospitals. A few plans shown as providing benefits in public mental hospitals limit benefits to small allowances per day.

at an additional premium, giving some coverage; four provided ten to 20 or 21 days;^a 42 provided 30 or 31 days of coverage; 23 provided 70 or more days of coverage. In private nonprofit or proprietary mental hospitals, 22 of the plans offered no coverage, although two of these did offer some coverage through riders; 33 provided 30 or 31 benefit days; and 15 provided 70 or more days of benefits. As regards care in public mental hospitals, 40 plans provided no coverage (two offered riders giving some coverage), 22 provided 30 or 31 benefit days, and eight provided 70 or more days of coverage.

Under their most comprehensive contract (Table 2), the plans provided appreciably more days of care for general illness. Thus, all except one provided at least 70 days of benefits, 36 provided 120-125 days of coverage, and 27 gave coverage for 365 days or longer. However, there is not a great deal of difference in the coverage offered for mental illness under the most comprehensive and the most widely held contract. In fact, the great majority of plans offered the same benefits for mental illness under both contracts.

Under the most comprehensive contract, three plans provided no coverage of mental illness in general hospitals (but all offered some coverage under riders at an additional cost), 41 plans provided 30 or 31 days of coverage, and 22 provided 120 or more days of coverage.

TABLE 2
Duration of Benefits for General and Mental Illness
Under Most Comprehensive Contract
Blue Cross Plans, November 1974

Days of care provided	General illness in	Mental illness in		
	General hospitals	General hospitals	Private mental hospitals	Public mental hospitals
All plans	74	74	74	74
Zero	—	3 ^a	21 ^c	37
10	—	1	1	1
15	—	1	—	—
20-21	—	1	—	—
30-31	1	41 ^b	35 ^d	22 ^e
35	—	—	—	—
45	—	1	2	2
70	6	4	3	3
90-100	1	—	—	—
120-125	36	10	6	4
150-180	3	1	1	1
365	24	10	4	4
485	1	—	—	—
730	2	1	1	—

^aAll of these plans offer riders to cover care for 30 or more days.

^bTwo of these offer riders to cover care for 70 or more days.

^cOne of these offers a rider to cover care for 30 days.

^dTwo of these offer riders to increase days to 70 or more.

^eOne of these offers a rider to increase days to 70 or more.

Note: See note in Table 1.

coverage, and the remainder provided 45 to 730 days of coverage.

As regards public mental hospitals, 37 plans, under their most comprehensive contract, provided no coverage, 22 provided 30 or 31 days of benefits, and nine provided 120 or more days of benefits.

Actually, the situation as regards coverage for mental conditions was somewhat less favorable than these figures indicate. For example, a few plans which provided some coverage in mental hospitals did not provide full benefits, i.e., such as those in general hospitals, but only dollar allowances which probably would not cover the full cost of care at least in private mental hospitals. Another factor is that a few plans provided coverage only in mental hospitals that were member or participating hospitals, and there may be few or no mental hospitals in this category.

The situation is also less favorable as regards coverage of mental illness because the plans generally employed a different basis for defining benefit days per admission or period of time for mental illness than for general illness.

As regards care for general illness, all plans, under both their most widely held and most comprehensive contracts, specified a certain number of days per admission. They further specified that any subsequent admission is to be considered a new admission if a specified period of time has intervened since discharge from the previous admission; any readmission before the elapse of this "separation" period is considered to be a continuation of the first admission.

The great majority of the plans—63 out of 74—under both their most widely held and most comprehensive contracts, define this separation period as 90 days; one plan specified 120 days; others specified 60, 30, 28, or fewer days. The smaller the separation period, the more favorable it is for the subscriber.

However, a less favorable basis is generally used for defining benefits in mental illness. Thus, as regards care in general hospitals (Table 3), 34 plans, under their most widely held contract, specified a certain number of days per admission, but only 22 specified a separation period of 90 days or less; the other 12 required 120, 180, or 365 days to intervene before a subsequent admission would be considered as a new admission. The remaining 36 plans providing some benefits specified that the stated number of benefit days would be the maximum provided in a given period—18 specified a benefit year, i.e., the year beginning with an admission; 12 specified a contract year; four specified the calendar year; one plan specified two years; and one plan provided that the specified number of benefit days would be the maximum available during the subscriber's life.

The situation under the most comprehensive contract is so similar that there is no need to describe it.

As regards care in private mental hospitals, the more restrictive basis of defining benefits was generally em-

TABLE 3
Basis for Determining Benefits for Mental
Illness Under Most Widely Held Contract
Blue Cross Plans, November 1974

All plans	In general hospitals	In mental hospitals	
		Private	Public
All plans	74	74	74
No benefits provided	4	22	40
Basis not specified	—	4	—
Days per admission with specified days since discharge required for new admission			
Total plans	34	21	15
No minimum	1	—	—
30 days	1	—	—
60 days	2	2	2
90 days	19	10	7
120 days	1	—	—
180 days or 6 months	7	7	6
365 days or year	3	2	—
Days per period of time			
Total plans	36	27	19
Benefit year	18	13	9
Contract year	12	8	7
Calendar year	4	3	1
Two years	1	1	—
Life	1	2	2

ployed (22 provided no benefits and for four the basis of benefits was not indicated). Thus, under the most widely held contract, of the 48 plans which provided specified benefits, 21 provided a given number of days per admission, with 12 requiring a separation period of 60 or 90 days and nine requiring a separation period of 180 or 365 days; the other 27 plans provided a specified number of days per period of time, with 24 specifying a year on one basis or another, one, two years, and two, a lifetime.

The benefits for care in public mental hospitals were even more restricted than those for care in private mental hospitals (see Table 3).

The situation under the most comprehensive contract is approximately the same.

At this point it is appropriate to mention that in terms of number of persons covered, the benefits provided for mental conditions by Blue Cross plans would probably present a more favorable picture than that shown above. Generally, the smaller plans have the more restrictive benefits for mental conditions, while the larger ones have the more liberal benefits.

TRENDS IN COVERAGE

When the various Blue Cross plans were first established in the 1930's and 1940's, they quite generally

excluded all benefits for mental conditions or provided very few days of coverage as compared with those for general illness. Since then the plans have gradually tended to provide better benefits for mental conditions.

Tables 4 and 5, analogous to Tables 1, 2, and 3, show the distribution of Blue Cross plans as of June 1971 according to benefits provided for mental illness.

A comparison of the tables shows that there has been little change from 1971 to 1974, although there has been a slight liberalization of benefits.

Comparisons of the two sets of tables need to be made with care since somewhat different procedures were used in the two studies in categorizing the plans. In 1971, two plans were shown as providing no days for mental illness in general hospitals under the most widely held contract; in 1974, there were four such plans. But these four plans all offered riders giving coverage, and they would have been shown in 1971 as giving the number of days that

TABLE 4
Distribution of Blue Cross Plans by Days of Care
Provided for General Illness and for Mental Illness
in General Hospitals and in Private and
Public Mental Hospitals, June 1, 1971

Days covered	General hospitals		Mental hospitals	
	General illness	Mental illness	Private	Public
<i>Under most widely held contract</i>				
All plans	74	74	74	74
Zero	—	2	19	38
10	—	1	1	1
15	—	1	—	—
20-21	2	3	3	3
30-31	4	44	34	19
35	—	—	2	—
45	—	1	—	2
70	16	4	2	1
100	2	1	—	—
120-125	40	13	7	6
150-180	2	—	—	—
365	7	1	1	1
485	1	—	—	—
Unspecified	—	3	5	3
<i>Under most comprehensive contract</i>				
All plans	74	74	74	74
Zero	—	1	19	37
10	—	1	1	1
15	—	1	—	—
20-21	1	2	2	2
30-31	1	43	33	20
45	—	1	2	2
70	7	4	2	2
100	1	—	—	—
120-125	36	9	5	4
150-180	3	1	1	1
365	23	8	3	3
485	1	—	—	—
730	1	1	1	—
Unspecified	—	2	5	2

Source: Reed, Myers, and Scheidtmann, *op. cit.*, p. 46.

were provided in the rider. Actually, therefore, the situation in 1974 was more favorable in that there were no plans which did not offer some coverage of care for mental conditions in general hospitals, under one con-

TABLE 5
Distribution of Blue Cross Plans
by Basis for Determining Benefits
for Mental Illness, June 1971

Basis for determining benefits	General hospitals	Private mental hospitals	Public mental hospitals
<i>Under most widely held contract</i>			
All plans	74	74	74
Plans providing no benefits	2	20	38
Plans not specifying basis for determining benefits	3	3	1
Plans requiring specified days since discharge for any admission considered a new admission			
Total plans	30	21	14
Days: 60	2	2	2
90	18	10	6
120	1	0	0
180	6	7	6
365	3	2	0
Plans placing a limit on days within a specified period			
Total plans	39	30	21
Period: Contract year	12	8	7
Calendar year	5	4	2
Any 12-month period	19	14	9
Two years	1	1	0
Lifetime	2	3	3
<i>Under most comprehensive contract</i>			
All plans	74	74	74
Plans providing no benefits	1	18	38
Plans not specifying basis for determining benefits	3	4	1
Plans requiring specified days since discharge for any admission considered a new admission			
Total plans	32	24	15
Days: 60	2	2	2
90	21	13	8
180	6	7	5
365	3	2	0
Plans placing a limit on days within a specified period			
Total plans	38	28	20
Period: Contract year	12	8	7
Calendar year	5	4	1
Any 12-month period	19	13	10
Two years	1	1	0
Lifetime	1	2	2

Source: Reed, Myers, and Scheidemandel: *op. cit.*, p. 48.

tract or another, while in 1971, two plans gave no coverage at all under their most widely held contract.

In 1971, 20 plans, under their most widely held contract, provided more than 30 or 31 days of coverage for mental conditions in general hospitals; in 1974, 24 plans provided more than 30 or 31 days. In 1971, 12 plans, under their most widely held contract, provided more than 30 or 31 days in private mental hospitals; in 1974, there were 17 plans providing such coverage.

Under their most comprehensive contract in 1971, 24 plans offered more than 30 or 31 days of care for mental illness in general hospitals; in 1974, 27 plans provided more than 30 or 31 days of coverage. In 1971, 14 plans provided more than 30 or 31 days in private mental hospitals; in 1974, there were 17 such plans.

In general, however, the situation in 1974 was not greatly better than that in 1971 as regards coverage of mental illness.

SOME ADDITIONAL COMMENTS

In considering Tables 1, 2, and 3, one is struck by the wide diversity among the plans in coverage of mental illness. A few provided the same benefits for mental as for other conditions in both general and mental hospitals. The great majority provided no benefits, or quite limited benefits, in private mental hospitals. One wonders what has been the difference in experience, local situation, or background that resulted in such different policies.

The compilation made by the Blue Cross Association also shows days of care provided for tuberculosis (Table 7). One notes that many plans provided quite restricted benefits for tuberculosis, both in general hospitals and private and public tuberculosis hospitals. Most of the beds in hospitals that care only or mainly for patients with tuberculosis are in public hospitals. The restricted benefits provided in these hospitals were, it may be surmised, mainly due to the reluctance of the plans to pay for care which can frequently be obtained by the patient free or at minor cost from government sources. The same factor goes far to explain the limited benefits for mental conditions in public mental hospitals.

One of the reasons frequently cited by Blue Cross plan executives for the lower hospital benefits for mental than for general conditions is the large expense that might be incurred if full coverage of mental conditions were provided. This can hardly be the explanation of the lower benefits for tuberculosis, since this disease has now become almost a rarity and the days of care provided for it are statistically insignificant.

One suspects that in both cases history provides some part of the explanation for the lower benefits for both mental illness and tuberculosis; specifically, that the plans were originally started largely by general hospitals and were designed to serve the patients of these hospitals, and that past restrictions have been brought forward into the present with insufficient scrutiny as to the need for their continuation.

OR COOPERATING WITH BLUE CROSS PLANS

As already mentioned, an additional factor in the lower benefits provided by many plans for mental conditions is that many private mental hospitals and most public mental hospitals are not member or contracting hospitals of the plans, and that benefits provided to patients in nonmember or noncontracting hospitals are lower than those provided in member or contracting hospitals.

It is much more advantageous for a Blue Cross subscriber to be hospitalized in a member (contracting or cooperating) hospital than in a nonmember one because in a member hospital the subscriber receives service benefits, i.e., room and board and generally all of the special services; in a nonmember hospital, he receives only per diem indemnity allowances which may fall far short of the cost.

In order that information could be obtained on this point, the Blue Cross Association was asked to provide information on the number and bed capacity of private and public mental hospitals which were member (contracting or cooperating) hospitals of Blue Cross plans in

Association. It will be seen that as of November 1974 there were 96 private mental hospitals, with 9,436 beds, and 40 public mental hospitals, with 43,222 beds, that contracted or cooperated with the Blue Cross plans of their area.

According to *Hospital Statistics, 1974*, issued by the American Hospital Association, there were in the United States 200 private mental hospitals with 16,539 beds and 343 nonfederal public mental hospitals with 405,460 beds. So 48 percent of the private mental hospitals with 57 percent of the bed capacity were contracting or cooperating hospitals, and 12 percent of the nonfederal public mental hospitals with 11 percent of the beds were contracting or cooperating hospitals.

It would be very useful to know why more private and public hospitals are not member (contracting or cooperating) hospitals of the plans. Is it because they have not applied to the plan for membership status, believing nonmembership status for one reason or another to be more advantageous to them? Or is it because they have applied and were rejected by the plan for one reason or another? Are there some plans which have a fixed rule that private or public mental hospitals will not be accepted as member hospitals, and, if so, why?

TABLE 6
Psychiatric Hospitals Contracting or Cooperating with
Blue Cross Plans, by State, November 1, 1974

State	Public mental hospitals		Private mental hospitals		State	Public mental hospitals		Private mental hospitals	
	Number of hospitals	Number of beds	Number of hospitals	Number of beds		Number of hospitals	Number of beds	Number of hospitals	Number of beds
Alabama	—	—	—	—	Montana	—	—	—	—
Alaska	1	200	—	—	Nebraska	2	353	—	—
Arizona	—	—	2	123	Nevada	—	—	—	—
Arkansas	—	—	—	—	New Hampshire	—	—	—	—
California	1	248	22	1,725	New Jersey	7	13,299	2	365
Colorado	1	67	3	256	New Mexico	2	909	1	92
Connecticut	5	4,109	5	706	New York	—	—	2	251
Delaware	—	—	—	—	North Carolina	5	9,126	2	231
District of Columbia	—	—	1	131	North Dakota	1*	943*	—	—
Florida	—	—	—	—	Ohio	—	—	2	170
Georgia	—	—	3	146	Oklahoma	—	—	1	80
Hawaii	—	—	—	—	Oregon	—	—	—	—
Idaho	—	—	—	—	Pennsylvania	—	—	6	852
Illinois	—	—	3	400	Rhode Island	—	—	1	84
Indiana	6	5,820	3	125	South Carolina	—	—	1	50
Iowa	2	483	—	—	South Dakota	—	—	—	—
Kansas	—	—	2	207	Tennessee	1	194	1	50
Kentucky	—	—	2	384	Texas	—	—	6	374
Louisiana	—	—	2	140	Utah	—	—	—	—
Maine	—	—	—	—	Vermont	—	—	—	—
Maryland	—	—	5	582	Virginia	1	120	5	648
Massachusetts	—	—	—	—	Washington	2	2,195	2	131
Michigan	1	50	5	613	West Virginia	—	—	1	52
Minnesota	—	—	—	—	Wisconsin	—	—	4	284
Mississippi	2	5,106	—	—	Wyoming	—	—	—	—
Missouri	—	—	1	184	Total	40	43,222	96	9,436

*Cooperating, but no voting rights.

Source: Data compiled by the Blue Cross Association from the *Blue Cross Manual and Hospital Statistics, 1974* (American Hospital Association).

TABLE 7
Blue Cross Plans: Duration of Benefits for General
and Mental Illness and Tuberculosis, November 1974

GENERAL ILLNESS					MENTAL ILLNESS						TUBERCULOSIS					
Plans	Full benefit days	Par- tial days	Per- cent- age or amount	Sap- ra- tion period	General hospital			Mental hospital			General hospital			Tubercular hospital		
					Days	Basic		Days	Basic	Public	Days	Basic		Days	Basic	Public
ALA., Birmingham MWH MC	70 365	— —	— —	90 90	30 30	B-yr B-yr		30 30	B-yr B-yr		30 30	B-yr B-yr		30 30	B-yr B-yr	
ARIZ., Phoenix MWH MC	30 120	— —	— —	90 90	30 30	A-6mo A-6mo		30 30	A-6mo A-6mo		30 30	A-6mo A-6mo		30 30	A-6mo A-6mo	
ARK., Little Rock MWH ⁺ MC	120 120	— —	— —	90 90	30 30	B-yr B-yr	(1) (1)	— (1)	— (1)		30 30	B-yr B-yr		(1) (1)	— —	
CALIF., Los Angeles MWH MC	365 365	— —	— —	28 28	365 365	B-yr B-yr	365 365	B-yr B-yr	365 365		365 365	B-yr B-yr		365 365	B-yr B-yr	
Oakland MWH MC	100 365	— —	— —	90 90	100 365	A-90 (2)	— —	— —	— —		100 365	A-90 (2)		— —	— —	
COLO., Denver MWH MC	120 120	— —	— —	90 90	30 30	B-yr B-yr	30 30	B-yr B-yr	— —		120 120	A-90 A-90		120 120	A-90 A-90	
CONN., New Haven MWH MC	485 485	— —	— —	30 30	45(3) 45(3)	A-180 A-180	45(3) 45(3)	A-180 A-180	45(3) 45(3)		45(3) 45(3)	A-180 A-180		45(3) 45(3)	A-180 A-180	
DEL., Wilmington MWH MC	120 120	— —	— —	90 90	120(4) 120(4)	A-90 A-90	120(4) 120(4)	A-90 A-90	120(4) 120(4)		(5) (5)	— —		— —	— —	
D. C., Washington MWH MC	180 180	— —	— —	60 60	30 30	A-60(6) A-60(6)	30 30	A-60(6) A-60(6)	30 30		180 180	A-60 A-60		180 180	A-60 A-60	
FLA., Jacksonville MWH MC	31 31	— —	— —	90 90	31 31	B-con B-con	31 31	B-con B-con	31 31		31 31	B-con B-con		31 31	B-con B-con	

TABLE 7 (Continued)

GENERAL ILLNESS					MENTAL ILLNESS					TUBERCULOSIS				
Plans	Full benefit days	Par-tial days	Per-cent-ago or amount	Sepa-ration period	General hospital		Mental hospital		General hospital	Tubercular hospital		General hospital	Tubercular hospital	
					Days	Bas	Days	Bas	Days	Bas	Days	Days	Bas	Days
GA.														
Atlanta	120	—	—	90	(7)	—	—	—	(7)	—	—	—	—	—
MWH	365	—	—	90	(7)	—	—	—	(7)	—	—	—	—	—
MC	30	—	—	90	—	—	—	—	—	—	—	—	—	—
Columbus	30	—	—	90	30	B-con	—	—	30	B-con	—	—	—	—
MWH	120	—	—	90	30	B-con	—	—	30	B-con	—	—	—	—
MC	120	—	—	90	30	B-con	—	—	30	B-con	—	—	—	—
IDAHO.														
Boise	365	—	—	90	365	A-90	—	—	365	A-90	—	—	—	—
MWH	365	—	—	90	365	A-90	—	—	365	A-90	—	—	—	—
MC	365	—	—	90	365	A-90	—	—	365	A-90	—	—	—	—
ILL.														
Chicago	120	—	—	90	120	A-90	120	A-90	120	A-90	120	A-90	120	A-90
MWH	120	—	—	90	120	A-90	120	A-90	120	A-90	120	A-90	120	A-90
MC	120	—	—	90	120	A-90	120	A-90	120	A-90	120	A-90	120	A-90
Rockford	120	—	—	90	10	B-con	10	B-con	(5)	—	—	—	—	—
MWH	730	—	—	90	10	B-con	10	B-con	(5)	—	—	—	—	—
MC	730	—	—	90	10	B-con	10	B-con	(5)	—	—	—	—	—
IND.														
Indianapolis	120	—	—	90	120	A-90	120	A-90	120	A-90	120	A-90	120	A-90
MWH	180	—	—	90	180	A-90	180	A-90	180	A-90	180	A-90	180	A-90
MC	180	—	—	90	180	A-90	180	A-90	180	A-90	180	A-90	180	A-90
IOWA.														
Des Moines	365	—	—	90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
MWH	365	—	—	90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
MC	365	—	—	90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
Sioux City	365	—	—	90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
MWH*	365	—	—	90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
MC	365	—	—	90	30	A-180	30	A-180	30	A-180	30	A-180	30	A-180
KANS.														
Topeka	120	—	—	90	30(8)	B-con	30(8)	B-con(9)	120	B-con	—	—	120(10)	B-con(11)
MWH*	120	—	—	90	30(8)	B-con	30(8)	B-con(9)	120	B-con	—	—	120(10)	B-con(11)
MC	120	—	—	90	30(8)	B-con	30(8)	B-con(9)	120	B-con	—	—	120(10)	B-con(11)
KY.														
Louisville	70	—	—	90	31	A-90	31	A-90	(5)	—	—	—	—	—
MWH	120	—	—	90	31	A-90	31	A-90	(5)	—	—	—	—	—
MC	120	—	—	90	31	A-90	31	A-90	(5)	—	—	—	—	—
LA.														
Baton Rouge	120	—	—	90	30	B-yr	—	—	30	B-yr	—	—	—	—
MWH	120	—	—	90	30	B-yr	—	—	30	B-yr	—	—	—	—
MC	120	—	—	90	30	B-yr	—	—	30	B-yr	—	—	—	—
New Orleans	125	—	—	90	125	A-yr	30(12)	A-180	125	A-yr	30(12)	A-180	125	A-yr
MWH	125	—	—	90	125	A-yr	30(12)	A-180	125	A-yr	30(12)	A-180	125	A-yr
MC	125	—	—	90	125	A-yr	30(12)	A-180	125	A-yr	30(12)	A-180	125	A-yr

TABLE 7 (Continued)

GENERAL ILLNESS					FEVERAL ILLNESS					TUBERCULOSIS						
Plans	Full benefit days	Par-tial days	Per-cent- age or amount	Sepa-ration period	General hospital			Mental hospital			General hospital			Tubercular hospital		
					Days	Bas- is		Days	Bas- is		Days	Bas- is		Days	Bas- is	
N. J., Newark	120(19)	—	—	90	20	B-con		20	B-con		20	B-con		20	B-con	
MWH MC	365(20)	—	—	90	30	B-con		30	B-con		30	B-con		30	B-con	
N. M., Albuquerque	365	—	—	90	30	B-con		30	B-con		30	B-con		30	B-con	
MWH MC	365	—	—	90	30	B-con		30	B-con		30	B-con		30	B-con	
N. Y., Albany	70	—	—	90	30	B-con		30	B-con		(5)	—		—	—	
MWH MC	70	—	—	90	30	B-con		30	B-con		(5)	—		—	—	
Buffalo	120	—	—	90	30	B-cal		30	B-cal		120	A-90		120	A-90	
MWH MC	120	—	—	90	30	B-cal		30	B-cal		120	A-90		120	A-90	
Jamestown	120	—	—	90	(21)	—		(21)	—		(21)	—		(21)	—	
MWH MC	120	—	—	90	(21)	—		(21)	—		(21)	—		(21)	—	
New York	21	180	50%	90(22)	30(23)	B-yr		30(23)	B-yr		21(24)	B-yr		21(24)	B-yr	
MWH MC	120	—	—	90(22)	30(25)	B-yr		30(25)	B-yr		30(26)	B-yr		30(26)	B-yr	
Rochester	120	—	—	60	120	A-60		120	A-60		120	A-60		120	A-60	
MWH MC	120	—	—	60	120	A-60		120	A-60		120	A-60		120	A-60	
Syracuse	70	—	—	90	70	B-con		(27)	—		(5)	—		—	—	
MWH MC	120	—	—	90	120	B-con		(28)	—		120(29)	B-con		(28)	—	
Utica	120	—	—	90	30(30)	B-yr		—	—		(5)	—		—	—	
MWH MC	120	—	—	90	30(30)	B-yr		—	—		(5)	—		—	—	
Watertown	120	—	—	90	30(30)	B-yr		—	—		30	(29)		—	—	
MWH MC	120	—	—	90	30(31)	B-yr		—	—		120	A-90		—	—	
MWH MC	120	—	—	90	30(31)	B-yr		—	—		120	A-90		—	—	
N. C., Durham	70	—	—	90	30	A-365		30	A-365		70	A-90		70	A-90	
MWH MC	70	—	—	90	30	A-365		30	A-365		70	A-90		70	A-90	
N. D., Fargo	365	—	—	90	70	A-180		70	A-180		70	A-180		70	A-180	
MWH* MC	365	—	—	90	70	A-180		70	A-180		70	A-180		70	A-180	
OHIO, Canton	365	—	—	90	365	A-90		—	—		365	A-90		—	—	
MWH MC	365	—	—	90	365	A-90		—	—		365	A-90		—	—	

10

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TABLE 7 (Continued)

Plans	GENERAL ILLNESS			MENTAL ILLNESS				TUBERCULOSIS			
	Full benefit days	Par-tial days	Percent- age or amount	General hospital		Mental hospital		General hospital		Tubercular hospital	
				Days	Basls	Days	Basls	Days	Basls	Days	Basls
WISC. Milwaukee MWH MC	365 365	— —	90 90	(47) 90	A-90 A-90	(47) (47)	A-90 A-90	(5) (5)	— —	— —	— —
WYO. Cheyenne MWH MC	365 365	— —	90 90	30 30	B-con B-con	(1) (1)	— —	30 30	B-con B-con	(1) (1)	— —

CODE AND FOOTNOTES

A. Per admission (with specified period required between admissions).

B. During specified benefit period:

— calendar year

— contract year

— lifetime of member

— year (any 12-month period)

— subject to deductible

— subject to copayment

1. Care available in member hospitals only. Mental or tubercular hospitals are not member hospitals.

2. Covered under major medical portion of certificate, 80 percent.

3. Each visit to a hospital's day-care unit or night-care unit is counted as one day of hospital care.

4. In contracting acute hospitals regular certificate benefits are provided; in nonacute hospitals up to \$18 a day for room and board, plus certain hospital ancillary services.

5. Pulmonary tuberculosis, after diagnosis as such, is excluded.

6. Benefits available only in hospitals accredited by Joint Commission on Accreditation of Hospitals.

7. Rider available to provide regular benefits in a general hospital for tuberculosis and nervous/mental cases.

8. Endorsement is available to increase days of care to 90 or 120 per certificate year and per confinement.

9. Up to 80 percent of charges.

10. If operated by the State of Kansas.

11. Up to \$9 per day.

12. Room-and-board allowances only.

13. Plan excludes benefits for hospitalization in a federal or governmental institution.

14. In a specialized hospital located in the state of Maryland, which is approved by Blue Cross, up to \$20 per day toward hospital's usual charges.

15. This limitation shall not apply during any period of hospitalization when a major surgical procedure is performed.

16. Care for nervous and mental and tuberculosis cases is covered only in contracting hospitals which accept such cases and regular certificate benefits apply.

17. Excludes cases treated in any governmental hospital, such as a charity hospital, mental institution, sanitarium, or veterans hospital.

18. Riders available to increase days to 70 or 120 days of care during any 12-month period for nervous/mental cases and tuberculosis.

19. 120 full benefit days, plus \$5 per day for an additional 245 days per certificate year, for persons under 65, 60 days only per certificate year if age 65 through 69, and 30 days care per certificate year for persons age 70 or over.

20. 365 full benefit days per certificate year for persons under age 65, 120 days per certificate year for persons 65 or over.

21. Rider available to provide 30 days coverage.

22. A new benefit period starts when the subscriber has not received hospital care nor care in a rest, nursing, or convalescent home, institution, or a sanitarium (although the contract excludes hospital service for such care) during the previous 90 days, or when the subscriber has remained continuously in the hospital for a period of 12 months.

23. 21 full benefit days and nine discount days for care in a non-governmental general, contracting, or accredited hospital. (However, no benefits in a separate division of such hospital which contains more than 15 percent of the hospital's total beds or where the average stay in that separate division is more than 60 days.)

24. Hospitalization for pulmonary tuberculosis is limited, in any 12-month period, to post-operative care following surgery for up to 21 days in a non-governmental contracting or accredited hospital.

25. Hospitalization for mental or nervous disorders is limited, in any 12-month period, up to 30 days in a non-governmental general, accredited, or contracting hospital (except in a separate division of such hospital which contains more than 15 percent of the hospital's total beds or where the average stay is more than 60 days); or to an allowance of \$10 per day for up to 30 days in a non-governmental approved psychiatric hospital or in a separate psychiatric division of a non-governmental general contracting hospital which contains more than 15 percent of the hospital's beds or where the average stay is more than 60 days.

TABLE 7 (Continued)

26. Hospitalization for pulmonary tuberculosis is limited, in any 12-month period, up to 30 days in a nongovernmental general, accredited, or contracting hospital; or to an allowance of \$10 per day for up to 30 days in a nongovernmental accredited hospital specializing in tuberculosis; and postoperative care.
27. Nonmember hospital benefits in accredited private psychiatric hospital—\$16 for a one-day stay; \$14 per day for the 2nd through 70th day.
28. Nonmember hospital benefits in accredited private psychiatric hospitals—80 percent of hospital's charges for semiprivate accommodation, not to exceed \$16 per day; 80 percent of other certificate services.
29. Pulmonary tuberculosis is covered in a general hospital only during that period of hospital confinement following a surgical operation for the treatment of such condition and limited to the period necessary for such operation and postoperative care not to exceed 30 days in any benefit period.
30. Excluded in certificate but covered administratively for 30 days per year in general hospitals only.
31. Nervous or mental disorders are covered in a contracting nongovernmental general hospital for 30 days in any 12-month period. Such care shall not be available in a separate division of a general hospital where that separate division contains more than 15 percent of the total beds in that hospital or where the average length of stay in that separate division is more than 60 days.
32. In specialized hospitals, tuberculosis, nervous, and mental cases are limited to 30 days of care during the lifetime of the member, with a maximum allowance of \$16 per day for such care if the hospital is nongovernmental and with a maximum allowance of \$5 per day if the hospital is governmental.
33. The plan will pay \$15 per day plus \$150 for other certificate services for a semiprivate room contract and \$14 per day plus \$140 for other certificate services for a ward contract.
34. Allows \$15 per day in approved specialized nonmember hospitals.
35. Rider available to provide 30 days of care per year in a nonprofit general hospital.
36. Any admission for an accident is considered a new admission.
37. 120 days for each such period (of hospitalization) during the certificate year.
38. Regular benefits in contracting hospitals, 70 percent of charges in noncontracting hospitals.
39. Room accommodations plus 80 percent of the hospital's regular charges for other covered services.
40. Mental and nervous diseases and pulmonary tuberculosis are covered for number of days of care of certificate for each confinement period in participating hospitals operating facilities for treating such cases and which regularly admit them. In licensed hospitals operated primarily for or generally recognized as hospitals for the treatment of mental and nervous disorders and pulmonary tuberculosis, the plan pays up to \$12.50 per week for a period of eight weeks per hospital confinement. Care is available for subsequent confinements when the last date of discharge and the date of readmission are separated by more than six months.
41. Rider available to provide care for pulmonary tuberculosis or nervous and mental disorders for 10, 30, 70, or 120 days during any 12-month period.
42. When employee returns to work on a full-time basis, any subsequent admission is considered as a new admission. If readmission to the hospital for the employee or dependent is the result of an accidental injury, such readmission shall constitute a new confinement.
43. Groups of 5-24 are limited to 70 days per calendar year for nervous and mental conditions, alcoholism, or drug addiction.
44. Groups of 25-100 are limited to 120 days per calendar year for nervous and mental conditions, alcoholism, or drug addiction; pulmonary tuberculosis ... is covered.
45. Care for a member admitted to a registered bed patient to an approved noncontracting hospital for treatment is limited to weighted average room per contract per day plus 80 percent of charges for other certificate services for 30 days per calendar year.
46. Plan excludes hospital services received in any hospital operated or controlled by the United States or any governmental agency of the United States or any state or political subdivision thereof.
47. Regular benefits in contracting hospitals: up to \$5 per day in noncontracting hospitals.
48. Nervous and mental care is available up to 31 days per period of disability if group selected the 31-day duration option, and for 70 days per period of disability if group selected either the 70-day or 120-day duration as previously described. In contracting hospitals regular benefits are available. In noncontracting hospitals (including all satellite up to 80 percent of hospital's charges are provided for the same hospital services as available in contracting hospitals).

STUDY 4

FINDINGS OF A SURVEY OF SELECTED BLUE CROSS AND BLUE SHIELD PLANS REGARDING COVERAGE AND UTILIZATION OF CARE FOR MENTAL CONDITIONS, 1974

The purpose of this survey was to obtain detailed information on the coverage by Blue Cross and Blue Shield plans of care for mental conditions, particularly outpatient care, and the utilization of such care.

At the outset the Blue Cross Association and the National Association of Blue Shield Plans were contacted. The officials in charge of research at both organizations¹ agreed that they would make such a survey possible and would facilitate it by cooperatively sending a questionnaire, to be developed by the writer, to a number of selected Blue Cross and Blue Shield plans and urging the plans to respond.

A questionnaire was developed asking for coverage and utilization of a) hospital care, b) physicians' in-hospital services, c) outpatient care under supplementary major medical contracts, and d) outpatient care under basic benefit contracts covering physicians' services in the office and home.

The Blue Cross Association and the National Association of Blue Shield Plans sent the questionnaire to 16 pairs of cooperating or integrated Blue Cross and Blue Shield plans or to single (nonaffiliated) Blue Cross and Blue Shield plans.² Replies were received from 15 plans or pairs of plans.³ The responses are tabulated⁴ in the following tables dealing, respectively, with hospital care, in-hospital physicians' services, outpatient care under major medical programs, and outpatient care under basic benefit programs.

The data on coverage for outpatient care are believed to be particularly useful. The data on utilization are sparse.

A summary of the findings follows.

Table 1 shows nothing new. Similar data for all plans are shown in Study 3, "Blue Cross Hospital Benefits for Mental Illness."

Table 2 gives data on utilization of hospital care for mental conditions from ten plans. Hospital admissions for mental conditions in most plans were two, three, four, or five percent of admissions for all conditions. Days of care for mental conditions ranged, for most plans, from 29 to 83 days per 1,000 covered population (excluding one plan with rates so low as to be questionable), and days for mental conditions as a percent of days for all conditions ranged from 4.4 to 11.8. Annual covered charges for hospital care for mental conditions ranged from \$2.76 to \$5.19 per covered person—generally equal to three, four, or five percent of covered charges for all conditions. The greater part of the hospitalization for mental conditions was in general hospitals. All of these data are quite similar to those found for 1969 or 1970 in the last APA survey of Blue Cross Plans.⁵

Table 3, related to coverage of in-hospital physicians' services, gives a little more information on this coverage than has previously been available. It indicates that Blue Shield plans generally covered physicians' services in private mental hospitals as well as general hospitals. It indicates that there were generally no special exclusions or limitations on care of alcoholism or drug abuse. Generally, the number of visit days was limited to the same number of days of hospital care as was provided under hospital benefits by the companion Blue Cross plan.

Table 4 gives some utilization data for in-hospital physicians' services for four plans. Little new is added to what was known before.

Table 5 (in two parts) gives valuable new data on coverage of outpatient care of mental conditions under supplementary major medical contracts. Most of the plans had such contracts.

The data indicate wide variation in coverage among the plans under their most widely held contract (Table 5A). Of 11 plans or pairs offering such coverage (Blue

¹Joseph C. Woosley, Senior Vice President, Research and Development, Blue Cross Association, and David H. Reid, Operations Division, National Association of Blue Shield Plans.

²Blue Cross and Blue Shield plans serving the same area are usually affiliated—set up as separate corporations but with the same administrative personnel and frequently the same executive head. In some cases the plans are integrated, i.e., one organization is both a Blue Cross plan and a Blue Shield plan.

³The responses provided data from 12 Blue Cross plans and ten Blue Shield plans. There were 74 Blue Cross plans and 70 Blue Shield plans as of January 1974. The responding Blue Cross plans contained approximately 31 percent of the membership of all Blue Cross plans; the responding Blue Shield plans contained 36 percent of the membership of all Blue Shield plans.

⁴L. S. Reed, E. S. Myers, and P. L. Scheidemandel: *op. cit.*, pp. 85-87.

Shield plans operating independently do not offer this type of coverage), seven paid 50 percent (or less) of charges for outpatient care of mental conditions—as opposed to 80 percent for other conditions—and most had other inside limitations, *i.e.*, limitations on amount of reimbursable charges per visit, on number of visits per year, or on maximum benefits payable. Three plans paid 80 percent of charges with no special limitations, *i.e.*, they paid the same benefits for mental as for other conditions. The remaining plan offered a variety of options—from no coverage to 50 percent and to 80 percent, and with or without special maximums on benefits payable.

Most of the plans had no special limitations or exclusions on treatment modalities. Two excluded marital therapy or marital counseling; another plan specified that marital counseling must be done by a physician. Two restricted service to the patient only—meaning, probably, that collateral visits with other members of the family would not be paid for unless they were patients also.

The plans varied widely as to whether they would provide reimbursement for the charges of other practitioners, *i.e.*, psychologists, social workers, and psychiatric nurses. Most paid charges of psychologists for both testing and therapy and usually independently of a physician, *i.e.*, not requiring referral by or supervision of care by a physician. Of the few plans which would reimburse the charges of social workers or psychiatric nurses, most would only do so when the care was under the supervision of a physician.

There appears also to be wide variation as regards the types of outpatient psychiatric clinics whose charges were covered (Table 5B). Several plans indicated that their guide in this matter was the practitioner—that they would reimburse the charges of a psychiatrist in any setting for a valid diagnosis. Some plans would reimburse the charges of alcoholism or drug addiction rehabilitation centers, while others specifically excluded these. Some plans indicated that they would reimburse the charges of outpatient clinics only if such clinics were affiliated with hospitals.

The replies as to requirements that outpatient facilities must meet in order to be paid by the plan were not very conclusive. Some indicated state licensure and/or hospital accreditation by the Joint Commission on Accreditation of Hospitals (JCAH). The key factor to be borne in mind in considering the replies is that under major medical contracts reimbursement of incurred expenses is to the *subscriber* and not to the *facility*.

In general there was no difference in the basis of remuneration between individual private practitioners and clinics. For example, if the plan paid, say, 50 percent of charges, it would be 50 percent of a clinic's charges or

of an individual practitioner's charges. None of the plans indicated any difference between individual practitioners and clinics in the number of visits which would be paid for or maximum benefits payable.

As regards paying for services of a free-standing clinic providing general health services, such as a neighborhood health center, the replies suggest that few plans have a fixed policy on this. Presumably because the matter comes up rarely, if ever. (People with supplementary major medical coverage would rarely go to neighborhood centers for care.) Probably in most cases a charge would be reimbursed—if service was rendered by a recognized practitioner for a valid diagnosis. The major fact to be borne in mind is that under these contracts the plan pays the patient and not the practitioner or clinic and that any reasonable charge billed by or approved by a physician will probably be reimbursed.

Only one plan—the Cleveland, Ohio, Blue Cross Plan—had any data on utilization of care or benefits for mental conditions under major medical contracts. This plan reported that charges of psychiatrists and psychologists combined were 11.3 percent (psychiatrists were 11.1 percent, psychologists 0.2 percent) of charges of all physicians for outpatient care, and that charges of organized outpatient facilities amounted to six percent of those of psychiatrists and psychologists. It is evident that few plans develop statistics on utilization of major medical benefits by diagnosis.

Table 6 relates to coverage of outpatient care of mental conditions under *basic benefit* contracts. Only three plans (one available through riders) offered contracts which provided basic benefit, first-dollar coverage of physicians' services in the office and home for any condition. One of these is California Blue Shield, which, under its standard contract covering physicians' services in the office and home, paid only for an initial visit to establish a psychiatric diagnosis—no visits for psychotherapy. In other words, the only real coverage of outpatient care for mental conditions was under supplementary major medical contracts. (The coverage by some plans of UAW is an exception to this statement.)

IN CONCLUSION, this survey of a sample of Blue Cross and Blue Shield plans indicates that the plans are feeling their way forward in covering mental conditions and that most are hesitant to provide full coverage—the same as for other conditions. It further indicates that the plans feel that they have problems in covering outpatient care of mental conditions. Certainly, the policies of the individual plans varied widely. Conferences—local, state, regional, or national—between representatives of the profession and representatives of the plans might be helpful in identifying problems and reaching solutions.

TABLE 1

Certain Blue Cross and Blue Shield Plans,
Hospital Coverage—Benefits Provided for General
and Mental Conditions, August–October 1974

Plans	General conditions		Mental conditions in			Partial hospitalization provisions	Special exclusions or limitations
	Days	Basis	General hospitals	Private mental hospitals	Public mental hospitals		
California Blue Shield of California	365	SP/30	Not covered except by rider	—	—	—	—
Connecticut Blue Cross	120+365	SP/30	45 – SP/180	45 – SP/180	45 – SP/180	None (1 PD=1 D)	Effective 10/1/74, will pay for care in alcoholism treatment facility
Delaware Blue Cross	120	SP/90	Part of 120/A	Part of 120/A	Part of 120/A	None (1 PD=1 D)	In specialized care facilities for treatment of alcoholism or drug addiction, two 30-day periods during lifetime; one per 12-month period
Kentucky Blue Cross	70	SP/90	31 – SP/90	31 – SP/90	None	None	None
Maryland Blue Cross	70	SP/90	30 per 180 days	30 @ \$20 per day per 180-day period	30 @ \$20 per day per 180-day period	None (under study)	None
New York Blue Cross–Blue Shield, N.Y.C.	21+180 @50%	SP/90	30 per 12 months	30 per 12 months	None	None (1 PD=1 D)	None
New York Blue Cross, Syracuse	70	SP/90	70 – SP/90	None except in local member hospital	None	None	None
Ohio Blue Cross, Cincinnati	70–730	SP/90	Same	30 days @ \$25, lifetime	30 days @ \$5, lifetime	None	None
Ohio Blue Cross, Cleveland	120–730	SP/90	Same	In nonprofit only ¹	None (except UAW contract)	Yes (night care—2 for 1)	None in short-term hospitals. Specialty hospitals subject to medical review for continuing coverage via certification program
Pennsylvania Blue Cross, Philadelphia	50–120 ²	SP/90	30 – SP/365	30 – SP/365	30 – SP/365	30 – SP/365	None
Pennsylvania Blue Cross, Pittsburgh	120	SP/90	30 per 12 months	None	None	None	None
South Carolina Blue Cross	70	SP/90	30 per 12 months	None	None	None	None
Tennessee Blue Cross—135	120	SP/90	30 per 12 months	30 per 12 months	30 per 12 months	30 per 12 months	None

SP: Separation period—days since discharge required for new admission.

PD (under partial hospitalization): Partial day.

¹Approved care given under certification program in clusters of 30 days.

²Fifty days first year; 60 second; 80 third; 100 fourth; and 120 fifth year and thereafter.

Certain Blue Cross and Blue Shield Plans,
Hospital Care—Utilization in 1973

Plan	Condition and type of hospitalization	Annual admissions per 1,000	Annual days per 1,000	Annual covered charges per covered person
Connecticut Blue Cross	All conditions	92	619	\$96.48
	Mental conditions	4.5	73.3	5.16
	In general hospital	2.3	29.4	3.07
	In private mental hospital	0.4	12.3	1.09
	In public mental hospital	1.8	31.6	1.00
	Mental as percent of all	4.9%	11.8%	5.3%
Kentucky Blue Cross	All conditions	127	775	98.00
	Mental conditions	NA	NA	5.19
	Mental as percent of all	NA	NA	5.3%
Maryland Blue Cross ¹	All conditions	102.9	732	96.48
	Mental conditions	2.8	45	2.76
	In general hospital	1.4	19	2.04
	In private mental hospital	.4	8	.36
	In public mental hospital	1.0	18	.36
	Mental as percent of all	2.7%	6.1%	2.9%
New York City Blue Cross-Blue Shield	All conditions	74.8	630.8	NA
	Mental conditions	1.8	28.9	NA
	Mental as percent of all	2.4%	4.6%	NA
New York Blue Cross, Syracuse	All conditions	107.4	680.0	71.42
	Mental conditions	2.6	39.5	2.79
	In general hospital	2.5	37.2	2.66
	In private mental hospital	.1	2.3	.13
	In public mental hospital	—	—	—
	Mental as percent of all	2.4%	5.8%	3.9%
Ohio Blue Cross, Cincinnati	All conditions	127	986	97.57
	Mental conditions	5.11	82.98	4.87
	In general hospitals	3.97 ²	63.26 ²	4.14 ²
	In private mental hospital	.35 ²	5.66 ²	.25 ²
	In public mental hospital	.31 ²	6.26 ²	.05 ²
	Mental as percent of all	4.0%	8.4%	5.0%
Pennsylvania Blue Cross, Philadelphia	All conditions	455.5 ³	1,201.5	124.43
	Mental conditions	3.8	57.0	4.27
	Mental as percent of all	—	4.7%	3.4%
Pennsylvania Blue Cross, Pittsburgh	All conditions	323.11 ⁴	2,453.90 ⁴	302.89 ⁴
	Mental conditions	11.01 ⁴	108.84 ⁴	8.35 ⁴
	Mental as percent of all	3.4%	4.4%	2.8%
South Carolina Blue Cross-Blue Shield	All conditions	144	936	84.00
	Mental conditions	12	60	3.60
	Mental as percent of all	8.3%	6.4%	4.3%
Tennessee Blue Cross-Blue Shield	All conditions	155	1,010	81.48
	Mental conditions	3	5	.24
	Mental as percent of all	2.0%	0.5%	0.3%

¹Data for "special 70" contract.

²Figures do not add up to total.

³Probably includes outpatient admissions.

⁴Figures probably are per 1,000 contracts.

TABLE 3

**Certain Blue Cross and Blue Shield Plans,
Coverage of Physicians' In-Hospital Services
for Mental Conditions, August-October 1974**

Plan	Coverage
California Blue Shield	Standard plan provides initial consultation to establish diagnosis for each admission to hospital. Coverage of in-hospital care provided under a separate rider. Also provided under a comprehensive plan as well as a major medical superimposed on a basic plan.
Delaware Blue Cross-Blue Shield	Physicians' services in-hospital covered during the period(s) covered under the hospital plan (120 days all conditions). Services are covered in private mental hospitals. No condition is excluded. There are no special limitations compared to coverage for general conditions.
Kentucky Blue Cross-Blue Shield	Indemnity Blue Shield rider—70 days—beginning first day @\$5 per day. Paid on basis of in-hospital days (not doctors' hospital visits).
Maryland Blue Cross-Blue Shield	Maximum of 30 days covered per admission. Benefits apply in private mental hospitals. Plan pays usual, customary, and reasonable charges under most widely held contract. No special limitation by diagnosis.
New York Blue Cross-Blue Shield New York City	No limitation on number of visits covered per admission. Most contracts have a rider to permit coverage of services rendered in institutions, including private mental hospitals. Plan pays usual, customary, and reasonable charges. No condition excluded, and no special limitations as regards coverage.
New York Blue Cross-Blue Shield Syracuse	Typical coverage—includes up to 120 visits per contract year. Limited to general hospitals only. Benefits in private mental hospitals not covered. Benefits determined on basis of relative value scale. No special limitations or exclusions in connection with alcoholism or drug abuse.
Ohio Blue Shield, Cleveland	Number of visits unlimited. Service in private mental hospitals covered. Allowance per visit is according to usual, customary, and reasonable charges. No condition is excluded; no special limitations.
Pennsylvania Blue Shield	Under standard community contract, in-hospital mental coverage is limited to 30 days during any 12-month period. For master groups, will write and have written contracts providing for in-hospital mental days up to 365 days. Benefits provided in mental hospitals approved by JCAH or Pennsylvania Blue Shield. Amount of payment depends on type of contract, i.e., prevailing fee programs pay according to usual, customary, and reasonable charges; fee schedule contracts have wide range of allowances—depending on particular schedule purchased. See below for illustration of allowances. No special limitation on conditions. No special exclusions.
South Carolina Blue Cross-Blue Shield	Visits limited to one visit per day for a period not to exceed 30 days during 12 consecutive months. Effective 12/1/74, visits limited to 30 days per calendar year. All mental conditions, including alcoholism and drug addiction, are covered.
Tennessee Blue Cross-Blue Shield	Thirty visits during 12-month period. Covered in private mental hospitals. Plan pays \$5 per day. All mental conditions, including alcoholism and drug addiction, are covered.

Pennsylvania Blue Shield—Illustration of Allowances

	Plan A	Plan B	Plan C
Limited psychiatric consultation	\$10.00	\$15.00	\$25.00
Comprehensive psychiatric consultation	10.00	30.00	35.00
Initial psychiatric hospital visit (limited)	15.00	20.00	25.00
Initial psychiatric hospital visit (comprehensive)	15.00	30.00	35.00
Psychiatric hospital visit (brief)	3.00	5.00	7.00
Psychiatric hospital visit (intermediate)	3.00	7.00	9.00
Psychiatric hospital visit (extended)	3.00	10.00	12.00

TABLE 4
Certain Blue Cross and Blue Shield Plans,
Utilization of Physicians' In-Hospital Medical Visits^a
for Mental Conditions, 1973

Plan	Annual cases per 1,000	Annual visits (or visit days) per 1,000	Annual covered charges per person covered
Maryland Blue Shield	Covered charges for in-hospital visits for mental conditions amount to approximately 9 percent of covered charges for in-hospital medical visits for all conditions.		
New York Blue Shield, Syracuse	All conditions 326 Mental conditions 9 Mental as percent of all 2.8%	1,289 57 4.4%	\$10.24 1.00 9.8%
South Carolina Blue Cross-Blue Shield	All conditions 132 Mental conditions 5 Mental as percent of all 3.8%	516 36 7.0%	6.00 .48 8.0%
Tennessee Blue Cross-Blue Shield	All conditions 74 Mental conditions 1 Mental as percent of all 1.4%	531 17 3.2%	3.36 .12 3.6%

^aIn considering this comparison of visits or visit days for mental and general conditions, it should be borne in mind that in-hospital medical visit days are only a part of all benefits under surgical-medical benefits, other benefits being surgery, anesthesia, X-ray and laboratory services, etc.

TABLE 5A
Certain Blue Cross and Blue Shield Plans,
Coverage of Outpatient Care of Mental Disorders Under Supplementary
Major Medical Contracts, August-October 1974

Plan	Benefits: percent of charges paid; limitations, maximums; deductible (see note); etc.	Special limitations on treatment modalities	Other practitioners whose services will be paid for		
			Practitioner	Yes or no	Independently of a physician
California Blue Shield	50% of the first \$20 of charges per visit; maximum, 50 visits per year. Option, 50% of the UCR fee not to exceed \$20 per visit; maximum, 100 visits per calendar year.	None	Psychologist for testing Psychologist for therapy Social worker Psychiatric nurse	Yes Yes No No	Yes Yes — —
Connecticut Blue Cross	50% up to maximum of \$510 a year.	None for psychiatrist ^a	Psychologist Social worker Psychiatric nurse	No No Yes	— — No
Delaware Blue Cross- Blue Shield	80%—same as other conditions; no special limitations.	None	Psychologist for testing Psychologist for therapy Social worker Psychiatric nurse	Yes Yes No No	Yes Yes — —
Kentucky Blue Cross- Blue Shield	80%; no special limitations.	None	Only service by medical doctor will be paid for		

TABLE 5A (Continued)

Plan	Benefits: percent of charges paid; limitations, maximums; deductible (see note); etc.	Special limitations on treatment modalities	Other practitioners whose services will be paid for		
			Practitioner	Yes or no	Independently of a physician
Maryland Blue Cross-Blue Shield	MWH pays 25% up to \$25,000 maximum. (Other conditions 80% up to \$25,000.) ¹ Other contracts pay more liberally.	Marital therapy excluded	Psychologist for testing Psychologist for therapy Psychiatric social worker Psychiatric nurse	Yes Yes Only under M.D. supervision Only under M.D. supervision	No ^b Yes Yes
New York Blue Cross-Blue Shield, New York City	Majority of contracts pay only 50% up to benefit limits of \$500 or \$1,000. Other conditions reimbursed at 80%.	None	Psychologist for testing Psychologist for therapy	Yes Yes	Yes Yes
New York Blue Cross-Blue Shield, Syracuse	No data provided; may not have major medical coverage.	—	—	—	—
Ohio Blue Cross, Cincinnati	No data provided.	—	—	—	—
Ohio Blue Cross, Cleveland	Varies from no coverage to 50% to same (80%) as for other conditions. Can vary from inside limit of \$1,000 to \$2,500, to no limit—same as for other conditions. Some contracts limit charges to \$30 per visit, i.e., \$15 maximum benefit per visit.	Marital counseling excluded	Psychologist for testing ^c Psychologist for therapy ^c Social worker Nurse	Yes Yes Only as part of outpatient facility Only as part of outpatient facility	Yes Yes
Ohio Blue Shield, Cleveland	Does not have major medical contracts. See basic contracts covering physician office care.	—	—	—	—
Pennsylvania Blue Cross, Philadelphia	50% of charges in excess of \$100 deductible up to maximum of \$2,500, or \$10,000, depending on size of group. Maximum of \$40 per visit. For other conditions, plan pays 80% up to maximum of \$25,000, \$50,000, or \$250,000.	Family therapy is covered but family is considered as an individual for benefits. Marital counseling must be by M.D.	Psychologist for testing Psychologist for therapy Social worker Psychiatric nurse	Yes No No Only under M.D. supervision	No — —
Pennsylvania Blue Cross, Pittsburgh	50% of charges up to maximum of \$20 per visit. 80% of charges paid for other conditions.	For patient only	No other practitioners	—	—
Pennsylvania Blue Shield	No major medical contracts.	—	—	—	—
South Carolina Blue Cross-Blue Shield	Offered as rider—MWH pays 50% of covered charges not exceeding \$20, and not more than 50 visits a year. 80% of charges paid for other conditions.	—	—	—	—
Tennessee Blue Cross-Blue Shield	80% for all conditions; no special limitations.	Covers service to patient only	Psychologist for testing Psychologist for therapy Social worker Psychiatric nurse	Yes Yes No No	Yes No —

^aFamily therapy, marital counseling not covered except when service provided by psychiatrist.

^bOnly when ordered by an M.D.

^cReferral by an M.D. no longer required.

Note: All plans have a deductible—usually \$50 or \$100 per person per year. Under all plans, the deductible for mental disorder cases was the same as that for all conditions.

TABLE 5B
 Certain Blue Cross and Blue Shield Plans,
 Coverage of Outpatient Care of Mental Disorders Under Supplementary
 Major Medical Contracts, August-October 1974

Plan	Outpatient psychiatric clinics that plan will pay—types and qualifications ¹	Requirements (licensure and other) that organizations must meet	Remuneration—basis and any differences compared with that for individual practitioners	Differences in visits or benefits compared with private practitioners	Will plan pay for services of free-standing clinics providing general health services such as neighborhood health centers?
California Blue Shield	All outpatient psychiatric clinics that are not funded by federal or state government, and are licensed outpatient clinics with exception of rehabilitation centers.	State licensure and, generally, accreditation by JCAH.	In accordance with terms of policy; none.	In accordance with terms of policy.	Yes, those meeting the following requirements: approved by local comprehensive health planning council; local medical society endorsement; state licensure; application for survey by JCAH and for CMA Committee on Medical Staff Surveys; approved by Blue Shield of California.
Connecticut Blue Cross	When accredited as part of a hospital.	Hospital accreditation by JCAH.	Cost reimbursement for institutions, charges for private practitioners.	None.	No.
Delaware Blue Cross and Blue Shield	Outpatient psychiatric clinics; community mental health centers; child guidance clinics; alcoholism or drug addiction rehabilitation centers.	State licensure. Staffing patterns and staffing standards, utilization review programs.	Charges. Level of remuneration to clinics is lower than that for individual practitioners. ²	None.	"None in this area, so have not developed policies."
Kentucky Blue Cross and Blue Shield	Will pay charges submitted by an M.D. in any of the specified types of clinics, except pastoral counseling clinic or service.	Must have M.D. on staff.	No difference with that for individual practitioners.	None.	"Don't know what free-standing clinic means. Don't think we would pay for services of such clinics."
Maryland Blue Cross and Blue Shield	Plan does not cover institutional charge of nonhospital outpatient clinics, but does cover the professional fee for services rendered in these settings.	Not applicable.	Not applicable.	Not applicable.	Not applicable.
New York, N.Y.C. Blue Cross and Blue Shield	A recognized practitioner may be affiliated with any of these types of clinics; criteria are the practitioner's status and validity of diagnosis reported.	Not applicable.	Not applicable.	Not applicable.	See answer in column one. Will pay a recognized practitioner in any setting. Criterion is the practitioner—not the setting.
New York, Syracuse Blue Cross and Blue Shield	No data provided. May not have supplementary major medical coverage.	—	—	—	—
Ohio, Cincinnati Blue Cross	No data provided.	—	—	—	—
Ohio, Cleveland Blue Cross	"Generally follow Steel guidelines in all our business. Not certain of pastoral counseling." (Note: Steel contract covers visits to "approved outpatient psychiatric facility," but what these are is not specified. The writer expects that any visits to a facility with M.D. on staff, or on referral from M.D., would be covered. State licensure and other standards of plans must be met.)		Remuneration would be same as for other services—80% of charges up to maximum of \$1,500.	None.	Yes, providing charges are billed by or approved by M.D.

Plan	Outpatient psychiatric clinics that plan will pay—types and qualifications ¹	Requirements (licensure and other) that organizations must meet	Remuneration—basis and any differences compared with that for individual practitioners	Differences in visits or benefits compared with private practitioners	Will plan pay for services of free-standing clinics providing general health services such as neighborhood health centers?
Ohio, Cleveland Blue Shield	No major medical contracts.	—	—	—	—
Pennsylvania, Philadelphia Blue Cross	Alcoholism and drug addiction rehabilitation centers are <i>not</i> covered. Presumably other types of clinics are covered	Cases are reimbursed on an individual basis, i.e., the clinics are not reviewed. Reimbursement is always to the subscriber.	Subscriber is reimbursed—not the clinic. The level of benefits is the same.	None.	Yes, if treatment is under an M.D. or D.O. Reimbursement is to the subscriber.
Pennsylvania, Blue Shield of Pennsylvania	Has no major medical contracts.	—	—	—	—
Pennsylvania, Pittsburgh Blue Cross	Plan covers only outpatient visits by patient to a licensed physician. "There is a lack of psychiatric outpatient facilities in the geographic area served by the plan."	—	No remuneration contracts or arrangements are considered in the major medical program. Reimbursement is to the subscriber.	None—not applicable.	Not applicable. Plan will reimburse subscriber for covered services by whomever rendered, i.e., by M.D. or on referral of M.D.
South Carolina Blue Cross and Blue Shield	"Special contractual arrangements limited." Apparently plans will pay for clinic care only for state employee group.	Facilities paid for state employee group are approved by state.	Special arrangements based on cost to patient.	Not applicable.	No
Tennessee Blue Cross and Blue Shield	Covers those services which would be covered in psychiatrist's office.	Must be a licensed hospital.	No difference.	None.	Only if licensed as a hospital.

¹For example, community mental health center, child guidance clinic, family counseling service, pastoral counseling clinic or service, alcoholism or drug addiction rehabilitation center.

²The writer believes this means that what they pay to clinics per visit is less than charges per visit to practitioners.

TABLE 6
Certain Blue Cross and Blue Shield Plans,
Outpatient Service for Mental Conditions Under Basic Benefit Contracts
Covering Physicians' Services in Office, August-October 1974

Plan	Services for mental conditions
California Blue Shield	Standard contract covering physician service in office and home pays only for one initial visit to establish psychiatric diagnosis.
Connecticut Blue Cross	No contracts of this nature.
Delaware Blue Cross and Blue Shield	Outpatient professional service in office and home not covered for any condition under benefits.
Kentucky Blue Cross and Blue Shield	Outpatient professional service in office and home not covered for any condition under benefits.
Maryland Blue Cross and Blue Shield	Same as above. But first dollar benefits for these services are available under riders.
New York, N.Y.C. Blue Cross and Blue Shield	No contracts providing outpatient care for any condition under basic benefits.
New York, Syracuse Blue Cross and Blue Shield	No contracts of this nature.
Ohio	
Cincinnati — Blue Cross	No contracts of this nature.
Cleveland — Blue Cross	No contracts of this nature.
Cleveland — Blue Shield	1-5 visits, 100%; 6-10 visits, 85%; 11-15 visits, 70%; 16 visits and over, 55%. Maximum benefit, \$400 per person per year. No deductible. (Note: This is Auto Workers' program.) Family therapy is limited to a maximum of 5 visits per calendar year if patient-member is an adult, maximum of 20 visits per year if a child (less than 19 years old). Under this contract, psychologists' services will be paid for, if qualified. This contract will pay for visits to hospital outpatient departments, psychiatric clinics, day and night treatment centers and community mental health centers. There are no differences in level of remuneration and number of visits as between clinic and private practitioners.
Pennsylvania	
Philadelphia Blue Cross	No contracts providing basic benefits for outpatient physicians' services.
Pennsylvania Blue Shield	No contracts providing basic benefits for outpatient physicians' services.
South Carolina Blue Cross and Blue Shield	No contracts providing basic benefits for outpatient physicians' services.
Tennessee Blue Cross and Blue Shield	No contracts providing basic benefits for outpatient physicians' services.

STUDY 5

COVERAGE OF MENTAL CONDITIONS UNDER HEALTH BENEFIT PLANS OF SELECTED UNIONS

This study was restricted to certain unions specified by the National Institute of Mental Health, namely, the United Steelworkers of America (for the steel, can, aluminum, and copper industries), the United Auto Workers (UAW), Teamsters, Electrical Workers (IUE and IBEW), Meat Cutters, and Rubber Workers.

It should be borne in mind that each of those unions has many locals and many contracts with different employers. The International Union of Electrical, Radio and Machine Workers (IUE), for example, has 30,000 contracts. Generally, however, the contracts with the largest employers in each industry tend to set the pattern for contracts with other employers. This study concerns itself with the contracts of each union with one or two of the larger companies.

There is some duplication between this study and Study 2, "Comparison of Benefits for General and Mental Conditions Under Employee Health Benefit Plans, 1974," since frequently the same companies in each industry are involved. However, the summaries in the Bureau of Labor Statistics' *Digest* (on which Study 2 is based) sometimes do not give details that are important from the standpoint of coverage of mental conditions. The material that follows has been taken from the insurance booklets issued by the companies involved to their employees. These set forth in detail the health benefits available.

UNITED STEELWORKERS OF AMERICA

Steel industry

The union has negotiated the same health benefits with all the major steel producers. The following is from the insurance booklet of U.S. Steel.¹

Hospital care. For general illness, 365 days per confinement are covered for employees with less than ten years of service, and 730 days are covered for those with

ten or more years of continuous service. For mental or nervous conditions, hospital benefits are limited to 60 days during any 12-month period.

Physicians' services under basic benefits. Surgical and in-hospital physicians' services are covered on the basis of full payment of prevailing and reasonable charges. In-hospital physicians' visits are covered for 365 or 730 days per confinement for general illness, and for 60 days during any 12-month period for mental or nervous conditions.

Diagnostic X-ray service is covered in or out of hospital up to a maximum of \$150 during any 12-month period. The same applies to diagnostic examinations.

Major medical expense benefits. The plan pays 80 percent of covered medical expenses in excess of a deductible of \$50 per person (\$100 for a family), up to a maximum benefit of \$15,000 for any one year and \$25,000 for a lifetime, with automatic reinstatement provisions. Covered expenses include services of physicians and dentists (for correction of damage caused by accidents), hospital care, diagnostic X-ray and laboratory procedures, services of a registered graduate or licensed practical nurse, prescription drugs, ambulance service, artificial limbs or other prosthetic appliances, rental of durable medical equipment, and various other minor items.

For mental and nervous conditions, expenses are covered on the same basis (*i.e.*, 80 percent), but the maximum benefit payable in any year is limited to \$1,500. Covered medical expenses include (in addition to those enumerated above):

Visits to a physician for individual psychotherapeutic treatments in the physician's office or in an approved outpatient psychiatric facility.

Visits to a physician by members of the patient's family for counseling. . . .

Visits to a physician for group psychotherapeutic treatment. . . .

Psychological testing by a psychologist, when prescribed by a physician.

The following services when received in an accredited hospital outpatient department or an approved outpatient psychiatric facility:

1. Professional and other necessary ancillary services, other than the services of a physician, if such service is

¹*Program of Insurance Benefits for Employees of U.S. Steel and Subsidiary Companies—Pursuant to Agreement with United Steelworkers of America—Hourly Paid Employees, and as Amended Effective August 1, 1971.* (Benefits remained the same under the 1974 Settlement Agreement except as mentioned later. This is the latest booklet available.)

provided through a day or night care program and is charged for by such hospital or facility as a part of regular institutional care and such program is approved by the Blue Cross.

2. Drugs and medication dispensed and charged for by such hospital or facility as a part of regular institutional care programs.

3. Electroshock therapy and anesthesia related thereto.

In order to qualify as Covered Medical Expenses, the psychiatric services must be rendered for treatment of certain emotional or mental conditions or illnesses which are amenable to favorable modification. Services in connection with mental deficiency or retardation are not covered.

The 1974 Settlement Agreement provided for a series of improvements in the medical program to become effective August 1, 1975. Among these is one pertinent to mental and nervous conditions, namely, "confinement up to 28 days for treatment of alcoholism and drug addiction [is] covered under hospital expense benefits for treatment in approved rehabilitation facilities. If the physician recommends treatment beyond 28 days, the benefits may be continued under the basic insurance plans."

The 1974 Agreement also provided for, effective August 1, 1975, a prepaid dental program for active employees (and dependents).

Can industry

The following summarizes the benefits of Continental Can Company (for steelworkers);² American Can has the same benefits.

Hospital care. Semiprivate care is provided for up to 365 days per confinement (up to 730 for employees with more than ten years of service) and the full cost of ancillary services. *There are no special limitations on care for mental conditions.*

Convalescent nursing home benefits. Benefits are provided for up to 365 days (every two days are charged as one day of regular hospital care). There are no special limitations on coverage for mental conditions, except that "confinements for psychiatric conditions (including mental illness and incompetency) are covered only after immediately preceding regular hospital confinement of at least five days." However, "no benefits are payable for . . . care in homes which exist primarily for care of alcoholics, drug addicts, the deaf, the blind, the mentally deficient, or persons suffering from tuberculosis or mental or nervous disorders."

Outpatient psychiatric care. The "Triple-C" group insurance program provides benefits for outpatient psychiatric care in either a physician's office or an approved outpatient psychiatric facility.

An approved outpatient psychiatric facility (including such facilities providing Day or Night Care Programs) means an administratively distinct unit or portion thereof which provides outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility and who assumes the overall responsibility for coordinating the care of all patients.

The facility must qualify as: An Outpatient Psychiatric Facility of an Accredited Hospital, or An Outpatient Psychiatric Clinic which meets the minimum standards established by the American Psychiatric Association as published in its *Standards for Psychiatric Hospitals and Clinics*, or A Community Mental Health Center, as defined by the Federal Government in the Community Mental Health Centers Act of 1963.

The benefits are as follows:

For visits to a physician for psychotherapeutic treatment in the physician's office or in an approved outpatient psychiatric facility, your "Triple-C" Group Insurance will pay the "reasonable and customary" charge for the first five visits, 70 percent of such charge for the next five visits, and 55 percent of such charge for the balance of visits.

For visits to a physician by members of the patient's family for counseling in the physician's office or in an approved outpatient psychiatric facility, the Plan will pay 85 percent of the "reasonable and customary" charge for up to five visits if the patient is an adult (age 19 or over), and if the patient is a child, on the basis as described in [the paragraph] above, for up to 20 visits.

For visits to a physician for group psychotherapeutic treatment in the physician's office or in an approved outpatient psychiatric facility, your "Triple-C" Group Insurance will pay 85 percent of the "reasonable and customary" charge for such visits.

For psychological testing by a Psychologist, when prescribed by a physician, the Plan will pay 85 percent of the "reasonable and customary" charge for such testing, up to a maximum benefit of \$38.25 per individual for services received during the immediately preceding 12-month period.

A Psychologist means a person who holds a degree in clinical psychology recognized by the American Board of Examiners in Professional Psychology, and who performs such services in accordance with any laws of the state in which such services are rendered.

Your "Triple-C" Group Insurance will pay the "reasonable and customary" charge for the following services when received in an approved outpatient psychiatric facility:

Professional and other necessary ancillary services, other than services of physicians, if such service is provided as part of regular institutional care and such Program is approved by the Insurance Company.

Drugs and medications dispensed and charged for by the facility rendering such treatments as a part of regular institutional care programs.

Electroshock therapy and anesthesia related thereto.

The above-mentioned services "must be rendered for treatment of those emotional or mental disorders or illnesses where such treatment can be expected to improve the patient's condition. Services in connection with mental deficiency and retardation are not covered.

²Group Insurance . . . Part of Your "Triple-C" Program of Protection, Established Pursuant to Agreement with the United Steelworkers of America as Amended February 15, 1971. (The same benefits were provided under the 1974 Agreement, with additions as mentioned later. This is the latest booklet available.)

"Benefits for psychiatric services are provided up to a combined maximum payment of \$400, per covered person, for services received during the immediately preceding 12-month period and are in addition to any benefits for inpatient psychiatric care provided under the program."

Surgery. "Reasonable and customary" charges are paid in full.

Physicians' hospital and nursing home calls. Visits for 365 days are paid for "on a reasonable and customary fee" basis but are limited to the first 120 days for mental conditions.

Diagnostic procedures. X rays, EKG, etc., and laboratory examinations are payable on a reasonable and customary fee basis in or out of hospital.

Major medical benefits. The plan pays 80 percent of covered medical expense in excess of a deductible of \$50 per person, \$100 for a family, up to a maximum of \$10,000 for any one year and \$20,000 for a lifetime, with reinstatement provisions.

Covered expenses are the usual ones. However, any services in connection with outpatient psychiatric care are excluded. So the only coverage of outpatient psychiatric care is that under "Outpatient Psychiatric Benefits," which is limited to \$400 in any 12-month period.

Aluminum industry

The following are the benefits of the Reynolds Metals Company and the Reynolds Mining Company.³ Benefits of the other major companies, such as Aluminum Company of America, are the same.

Hospital care. Three hundred sixty-five days per confinement are covered (730 if the employee has ten or more years of service), but benefits for mental or nervous disorders or pulmonary tuberculosis are limited to 120 days in any 12-month period.

Convalescent nursing home benefits. Benefits up to 365 days are provided, less any days of hospital care used. No benefits are provided in homes primarily for care of alcoholics, drug addicts, or mental or nervous disorders.

Surgical-medical. Full payment is provided of reasonable and customary fees for surgery, anesthesia, obstetrical service, diagnostic X rays, EKG's, BMR's, and physicians' in-hospital visits up to a maximum of 365 days. There is no special limitation on in-hospital visits for mental or nervous disorders.

Extended medical expense. The plan pays 80 percent of covered expenses in excess of a deductible of \$50 per person, \$100 per family, up to a maximum benefit of \$10,000 in any year or \$20,000 in a lifetime for any one illness or injury. (Covered expenses include hospital and

physicians' expenses not covered under basic benefits and physicians' services out of hospital, drugs, laboratory tests, prosthetic appliances, etc.)

There is no mention of any special limitation on coverage of mental conditions. The plan will pay benefits for covered expenses for mental and nervous conditions, at reasonable and customary charges, as follows:

Visits to a physician for individual psychotherapeutic treatment in the physician's office or in an approved outpatient psychiatric facility.

Visits to a physician by members of the patient's family for counseling in the physician's office or in an approved outpatient psychiatric facility.

Visits to a physician for group psychotherapeutic treatment in the physician's office or in an approved outpatient psychiatric facility.

Psychological testing by a psychologist when prescribed by a physician.

The following services when received in an accredited hospital outpatient psychiatric facility:

1. Professional and other necessary ancillary services, other than services of physicians, if such services are provided through a Day Care or Night Care Program and are charged for by the facility or hospital as a part of regular institutional care and such Program is approved by the Insurance Company.

2. Drugs and Medications dispensed and charged for by the hospital or facility rendering such treatments as a part of regular institutional care programs.

3. Electroshock therapy and anesthesia related thereto. The professional psychiatric services must be rendered for treatment of certain emotional, mental, or nervous disorders or illnesses which are amenable to favorable modifications. Services in connection with mental deficiency or retardation are not covered.

An "Approved Outpatient Psychiatric Facility" is defined as

an administratively distinct governmental, other public, private, or independent unit or part of such unit that provides outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the Facility and who assumes the overall responsibility for coordinating the care of all patients.

The term "Approved Outpatient Psychiatric Facility" includes centers for the care of adults or children of the nature of hospitals' outpatient psychiatric clinics, day treatment centers, night care centers, and Community Mental Health Centers as defined in the Federal Community Mental Health Centers Act of 1963. An "Approved Outpatient Psychiatric Facility" shall meet the standards as may be determined by the Insurance Company from time to time.

"Day Care Program" or "Night Care Program" means a program provided for patients with mental illness who spend part of a day or night in a planned treatment program in an approved therapeutic facility in a legally constituted hospital.

"Psychologist" means a person who is trained and experienced in the administration of psychological tests.

³Insurance Plan, 1971. (Benefits under the 1974 Agreement are the same, except as mentioned later. This is the latest booklet available.)

who holds a degree in clinical psychology recognized by the American Board of Examiners in Professional Psychology, and who performs such services in accordance with the laws of the state in which such services are rendered.

Additional medical benefits are to become effective June 1, 1975. These include prepaid dental programs, and, with respect to mental benefits, "alcoholism and drug addiction [are] covered under hospital expense benefits for treatments in approved rehabilitative facilities."

Copper industry

The following summarizes the health benefits of Kennecott Copper Corporation.⁴

Hospital care. Three hundred sixty-five days per confinement are covered in Blue Cross member hospitals, including all special services. The same number of days are covered for mental conditions in member hospitals. In mental hospitals, Blue Cross will pay regular charges of the institution for 52 weeks.

Surgical and in-hospital medical care. Full payment on the basis of usual and customary fees is provided for these services; in-hospital medical visits are limited to 120 days. Psychiatric care is limited to 30 days. Clinical psychologist benefits (for employees only) are limited to one visit per day.

Diagnostic X rays and laboratory tests. The plan provides up to \$35 in connection with surgery and up to \$100 in connection with accidents or illness.

Home and office visits. Benefits are for employees only and are on the basis of usual and customary fees for necessary office and home visits. There is no mention of any special limitation on mental conditions. Visits to company doctors are covered at no charge.

Major medical expense. The plan pays 80 percent of covered expense excluding a deductible of \$100 or benefits paid under the basic plan, whichever is greater. There is apparently no limit on maximum benefits. Covered expenses include hospital care, physicians' services, special nursing, drugs, and prosthetic appliances. The same benefits are provided for mental as for all other conditions.

Certain improvements were added by the new agreement, effective July 1, 1974. The improvements in health benefits, to become effective July 1, 1975, include, as regards mental conditions, the following: "Confinement for treatment of alcoholism and drug addiction [is] covered under hospital expense benefits in approved rehabilitation facilities. Criteria for such facilities [are] to be mutually agreed upon."

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW)

The union has negotiated the same basic benefits with each of the three major automobile manufacturers.

General Motors Corporation⁵

Hospital care. Full coverage is provided for 365 days per confinement. Care for psychiatric conditions is limited to 45 days.

Nursing home or extended care facility. Up to 730 days are provided on a basis of two days for each day of hospital care.

Surgery, anesthesia, and in-hospital medical care. Full payment is provided of usual, customary, and reasonable charges. There is no special limitation on in-hospital care of mental conditions.

Diagnostic X rays and laboratory tests. Full coverage is provided.

Prescription drugs. One hundred percent of charges in excess of \$2 per prescription are covered.

Outpatient psychiatric care. The plan pays up to \$400 in an approved psychiatric clinic, and up to \$400 (combined with any expense in a psychiatric clinic) for psychiatric services in a doctor's office, subject to certain deductible amounts which the employee must pay. The first five visits are covered at no charge; the patient pays 15 percent of the charges for the next five visits, 30 percent of the charges for the next five, and 45 percent of the charges for additional visits—up to the maximum benefit of \$400. [The last has been taken from other sources.]

Dental benefits became effective October 1, 1974.

Certain improvements will be made in outpatient psychiatric benefits effective October 1, 1975, but these have not yet been announced.

UAW'S HEALTH BENEFITS negotiated with major manufacturers in other industries tend to follow the same general pattern as for the auto industry, but there are some variations. The following were taken from the summaries in the *BLS Digest*.

Caterpillar Tractor Co. Hospital care is provided for 365 days for general conditions, 120 days for mental and nervous conditions. Convalescent care in an extended care facility is limited to 240 days for mental and nervous conditions. In-hospital medical care for mental conditions is limited to 120 days. Psychiatric benefits for care in an outpatient psychiatric facility and/or physician's office are provided up to \$1,000 per year; group psychiatric treatments are covered at 90 percent of charges.

⁴*Life Insurance . . . Accident and Sickness Insurance, and Hospital, Medical, and Surgical Benefits*, Kennecott Copper Corporation, Metal Mining Division and Subsidiary and the Participating Unions (expired June 30, 1974.)

⁵*What You Should Know About Your Benefits* (As Set Forth in Supplemental Agreements Between General Motors Corporation and the UAW Dated November 19, 1973). This brochure describes the health benefits in only general terms; some details here have been taken from other sources.

General Motors, but there are, for employees only, additional benefits of \$2 per physician visit and \$3.50 per home visit, up to a maximum benefit of \$350 per disability; there is no special limit on mental conditions.

International Harvester Co. Three hundred sixty-five days of hospital care are provided, with no special limitation on mental conditions. Convalescent care in an extended care facility is covered for up to 730 days, but is limited to 90 days for mental and nervous conditions. Coverage for in-hospital physicians' visits is unlimited for general conditions, but is limited to 365 days for mental and nervous conditions and to 26 days in a convalescent facility. Outpatient psychiatric benefits are the same as for the auto companies.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN AND HELPERS OF AMERICA (TEAMSTERS)

The Union has 2.3 million members, over 1,000 locals, and 40,000 contracts. The soon-to-be-published *BLS Digest* summarizes negotiated health benefits with Honeywell, Inc. (Minneapolis); Brewers (New York City); Milk Dealers (Chicago); Trucking Industry (Central States, Southeast, and Southwest Areas); and Trucking, Warehousing, and Other Industries. Various Associations and Individual Employers (Western States)—Teamsters (Western Conference).

An International official said four contracts covering the largest number of workers are with trucking industries of Central States, New York City Area, San Francisco Bay Area, and St. Louis Area. Insurance brochures of these contracts were obtained and the health benefits are summarized below.

Central States, Southeast, and Southwest Areas Health and Welfare Fund—Group Insurance Plan 76

Hospital care. Full coverage of charges for care in semiprivate accommodations, or at the semiprivate rate, is provided. There is no limit on days, nor on care for mental conditions.

Surgical expense. Indemnity allowances are furnished in accordance with a schedule. There is no in-hospital basic coverage.

Outpatient X-ray and laboratory services. Charges of up to \$50 or \$75 are covered.

Major medical. The plan pays 80 percent of usual covered expenses, after a deductible of \$100 plus basic benefits payable. *There is no coverage of any treatment of nervous or mental disorders except while hospitalized.*

Welfare Fund of New York City Trucking Industry, Local 807

Hospital care (by Blue Cross of New York City). One hundred twenty days are covered in full, plus 180 days at

covered, except care for one day for each of ten electroshock treatments and for 21 days for surgical care.

Medical and surgical care. The plan offers a choice between an "807 Plan" (written by the insurance company) and the Health Insurance Plan of Greater New York (HIP).

The "807 Plan" pays \$6 for physicians' office visits, \$8 for home calls, fixed allowances for hospital visits, and for surgery in accordance with a schedule of allowances. Apparently the same allowances are paid for visits by or to psychiatrists.

The HIP plan provides comprehensive coverage of physicians' services, but the Teamsters contract does not cover any psychiatric service other than that necessary to establish an initial diagnosis.

Bay Area Delivery Drivers Security Fund

Hospital care. Semiprivate room charge and charges for all special services are covered for 70 days. The same benefits apply for mental disorders.

Surgical care. Allowances are provided in accordance with a schedule.

Medical care. Ten dollars per day of treatment in office, home, or hospital, up to a maximum of \$300 is covered. There is no exclusion of mental disorders.

Major medical expense. The plan pays 80 percent of covered expenses in excess of \$50 per person per year and basic benefits payable up to \$15,000. *Charges for mental and nervous disorders are excluded unless incurred during hospitalization.*

St. Louis, Missouri, Area

Most (or all) Teamsters locals in the St. Louis Area obtain medical care benefits from the St. Louis Labor Health Institute—a group-practice prepayment unit organized and controlled by the Teamsters. Benefits are as follows:

Hospital care (through Blue Cross). Ninety days per confinement are covered for general conditions; 30 days are covered during any 12-month period for mental and nervous conditions.

Physicians' services. Complete care at the Institute Medical Center and in home and hospital is provided. Psychiatric care in hospital is limited to 30 days. Psychiatric care at the Medical Center is unlimited.

ELECTRICAL WORKERS INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS (IBEW) AND INTERNATIONAL UNION OF ELECTRICAL, RADIO AND MACHINE WORKERS (IUE)

Major employers for both these unions are General Electric Company and Westinghouse Electric Corpora-

tion. The two unions bargain jointly with each of these companies and the medical and insurance benefits are the same.

General Electric Company

Hospital care. The plan covers 100 percent of charges for a semiprivate room and special services for 365 days. The same coverage applies to mental disorders.

Surgical, diagnostic X-ray, and anesthesia services. The plan pays 100 percent of the first \$500 in each year, then 85 percent up to a lifetime maximum of \$250,000. The same benefits are provided for mental disorders.

Other medical bills (such as physicians' care, drugs, special nursing). The plan pays 85 percent of charges in excess of a deductible of \$50 per person per year up to the lifetime maximum. However, in case of "psychiatric treatments or consultations, if employee is not totally disabled so as to be prevented from working, or covered dependent is not confined in a hospital or similar institution, the rate of benefit will be 50 percent. . . ."

Westinghouse Electric Corporation

Hospital care. The plan pays 100 percent of charges for semiprivate care for 365 days. The same coverage applies to mental disorders.

Surgical care. Indemnity allowances are provided in accordance with a schedule, with a maximum of \$450 for any operation.

Diagnostic X rays and laboratory examinations. The plan pays charges up to \$150.

Major medical expense. The plan pays 85 percent of covered expenses in excess of basic benefits paid and a deductible of \$50 per person per year, up to a maximum of \$25,000. (Covered expenses include hospital care, physicians' services, drugs, special nursing, prosthetic appliances, etc.) However, for mental or nervous conditions, the plan pays only 50 percent while an employee is not totally disabled so as to be prevented from working, or while a dependent is not hospitalized.

Pacific Gas and Electric Company (under contract with IBEW)

Each employee has a choice of the Kaiser Health Plan or the Blue Cross Medical Service Plan.

Kaiser Health Plan

Hospital care. Unlimited care is provided for other conditions, but inpatient psychiatric care is not provided.

Professional benefits. Virtually complete care in hospital, clinic, or home is provided—but dependents pay \$1 for each office visit. However, outpatient psychiatric care is provided only at member rates for each visit or

service, i.e., is excluded under the prepayment plan. Inpatient or outpatient alcoholism care and care of drug addiction are not provided.

Blue Cross Medical Service Plan

Hospital care. Full service for 365 days is provided for general conditions.

Surgical care and in-hospital physicians' services. The plan pays in full for usual, customary, and reasonable charges.

Office and home visits. After a \$30 initial deductible per person per year, the plan pays usual, customary, and reasonable charges. Benefits for inpatient and outpatient psychiatric care are provided by major medical only.

Major medical. The plan pays 80 percent of the first \$2,000 of covered charges, 100 percent thereafter, in excess of a deductible of \$100 per person (\$300 per family) per year, up to a maximum of \$300,000. Eighty or 100 percent of charges are covered for inpatient psychiatric care during an acute phase, and 50 percent of charges for outpatient psychiatric care are covered, up to \$15 for each visit.

Alcoholism care. For inpatient care, the plan pays full hospital and professional benefits up to 60 days after at least seven consecutive days of hospital care. This is provided only once in a lifetime. For outpatient care, charges up to \$30 a visit per day are covered, up to \$600 during a 90-day treatment period each calendar year.

AMALGAMATED MEAT CUTTERS AND BUTCHER WORKERS OF AMERICA (MEAT CUTTERS)

An International Union official stated that the agreement with Armour and Company is a pattern for the meat-packing industry—and that "all of the other major and most of the independent packers in the industry" have the same or approximately the same health benefits.

Armour and Company

Hospital care. Three hundred sixty-five days for any confinement are provided, including charges for a semiprivate room and all special services. The same benefits for mental conditions are provided, except that hospital care for chronic alcoholism or drug addiction is excluded.

Surgical care. Allowances are furnished in accordance with a schedule, with a maximum benefit of \$500.

In-hospital physicians' services. The plan pays \$10 for the first visit and \$3 for each subsequent visit, to a maximum of \$1,102. There is no exclusion for mental conditions.

Major medical. The plan pays 80 percent of covered charges in excess of a deductible of \$300 (charges paid by

basic benefits can fulfill the deductible) up to a maximum of \$5,000 (\$15,000 effective September 1, 1975). *The same benefits are provided for mental conditions.* Covered expenses do not include charges for testing or care by a psychologist or care by any practitioner who is not a physician.

UNITED RUBBER, CORK, LINOLEUM AND PLASTIC WORKERS OF AMERICA (RUBBER WORKERS)

The Union provided the current pension and insurance booklets for Firestone Tire & Rubber Company, General Tire & Rubber Company, B. F. Goodrich Company, and Uniroyal, Inc.

All of these companies, in agreement with the Union, appear to have identical *basic benefits* for hospital-surgical-medical care. However, Firestone, alone among these companies, also has major medical expense benefits.

B. F. Goodrich Company

Benefits of this company are as described below. Basic benefits of the other three companies are identical or virtually so.

Hospital care. Care in semiprivate accommodations for 730 days per confinement and full coverage of all hospital special services are provided. There is no exclusion or limitation on care for mental disorders.

Outpatient diagnostic X-ray and laboratory tests and outpatient radiation therapy. Charges for diagnostic X-ray and laboratory tests are covered up to \$100 per person per year, for radiation therapy up to \$600.

Post-hospital confinement benefits. The plan pays charges for room and board in a convalescent nursing home (provided confinement is within 14 days of a hospital confinement of at least three days) up to a maximum of 50 percent of the hospital daily charge, up to the remaining days of the hospital benefit or 100 days, whichever is less. There is no exclusion or limitation on care of mental disorders, but care in any facility or institution which is used principally as a rest facility, a facility for the aged, or a facility for the *care of drug addicts or alcoholics* is excluded.

Visiting Nurse Service. The plan pays charges for care of a registered nurse employed by the Visiting Nurse Service, for care following a hospital confinement, up to a maximum of \$12.50 per day for not more than 100 visits.

Surgical care. Usual, customary, and reasonable charges for surgery, obstetrical, and anesthesia services are paid in full.

In-hospital medical care. The plan pays charges of physicians for in-hospital visits up to \$10 per visit day for 730 days. There is no exclusion of or limitation on care for mental disorders.

Prescription drug benefits. The plan pays charges for prescription drugs, with the patient paying \$1 for each prescription.

FIRESTONE TIRE & RUBBER COMPANY, in addition to the above benefits, has major medical benefits. These benefits pay 80 percent of covered charges (hospital care, physicians' services, physiotherapy, special nursing, ambulance, etc.) in excess of a deductible of \$100 per person (\$200 for a family), up to a maximum benefit of \$25,000 in any year or \$100,000 in a lifetime.

For mental illness or functional nervous disorder, only 50 percent of charges are paid for outpatient care, and only charges for the first 50 visits in a year are eligible; also, not more than \$30 per visit are eligible for reimbursement, *i.e.*, the maximum benefit payable per visit is \$15.

CONCLUSIONS

Close inspection of the health-benefit programs of the unions specified by NIMH leads to about the same conclusions reached in Study 2, "Comparison of Benefits for General and Mental Conditions Under Employee Health Benefit Plans, 1974," namely, *a*) that many companies provide the same hospital care and in-hospital physicians' service benefits for mental conditions as for general conditions, while others provide reduced benefits for mental conditions, and *b*) that most companies provide reduced benefits for outpatient care of mental conditions although a minority provide the same benefits as those for general conditions.

A more important conclusion, evident in contacts with union officials in obtaining copies of agreements or pension-insurance brochures, is that a considerable number of these officials have a keen interest in benefits for outpatient psychiatric care. This interest augurs well for improved outpatient psychiatric care benefits in the future.

STUDY 6

UTILIZATION OF CARE FOR MENTAL CONDITIONS UNDER CANADIAN GOVERNMENTAL HOSPITAL AND MEDICAL INSURANCE PROGRAMS*

Information on utilization under the Canadian federal-provincial programs of hospital and medical insurance is of interest because these programs, unlike most private health insurance in the United States, cover care for mental conditions on the same basis as care for other conditions and the coverage is complete—all needed care is provided.

HOSPITAL INSURANCE

Since 1958, Canada has had a program of federal cost-sharing with the provinces for hospital insurance; all of the provinces have been participating since January 1961. The federal government pays approximately 50 percent of the cost of approved provincial programs.

To qualify for federal cost-sharing a provincial hospital insurance program must provide complete care in general hospitals (ward accommodations) to all eligible residents on uniform terms and conditions. There can be no limit on the length of stay. Care must be provided for mental and nervous disorders on the same basis as for all other conditions. Most of the provinces finance their share of the cost of the program from general revenues and make care available to all residents. One province finances part of its share through premiums, and benefits are restricted to those who have paid the premiums or who qualify for public assistance, but only a very small percentage of the eligible population is uninsured. One or two provinces require the patient to pay a small amount for each day of care.

This program applies only to general and allied special hospitals, not to mental hospitals. All of the provinces have government mental hospitals that provide care free of charge or at very low charges to all residents.

*The author would like to express his appreciation of assistance rendered to him by the staff of the Health Economics and Statistics Unit of the Health Programs Branch of the Canadian Department of National Health and Welfare

Utilization experience

Hospital utilization is higher in Canada than in the United States. This was true before the program started. In 1971 the rate of hospital separations under the program for all conditions, as shown in Table 1, was 165.9 per 1,000 covered population, patient days were 1,920 per 1,000, and the average length of stay was 11.6 days. The comparable utilization rates for mental conditions were 6.1 separations and 109.8 patient days per 1,000 population and an average length of stay of 18.0 days. Thus, mental separations comprise 3.7 percent of all separations, and patient days for mental illness were 5.7 percent of days for all conditions.

As in the United States, the total number of days of care for mental conditions in general hospitals is relatively small in comparison with the days of care in mental hospitals. In 1971, the total days of care for mental conditions in Canadian general hospitals were about one eighth of the total days of care in Canadian mental hospitals.

TABLE 1
Utilization of Hospital Care for All Conditions
and for Mental Conditions Under the Canadian
Hospital Insurance Program, 1971

Diagnostic category	Sepa- rations per 1,000 pop.	Pt. days per 1,000 pop.	Average length of stay (days)	Percent of totals for all conditions	
				Sepa- rations	Pt. days
All conditions	165.9	1,919.7	11.6	100.0	100.0
Mental conditions	6.1	109.8	18.0	3.7	5.7
Psychoses	1.7	41.5	25.0	1.0	2.2
Neuroses, per- sonality disorders and other nonpsychotic mental disorders, and mental retardation	4.4	68.3	15.4	2.7	3.5

Source: Statistics Canada Hospital Morbidity, 1971.

MEDICAL SERVICE INSURANCE

In 1966 Canada enacted a law establishing a grant-in-aid program under which the federal government would make a financial contribution to those provinces operating medical care insurance plans meeting certain minimum criteria. These criteria relate to comprehensiveness of insured services, universality of coverage, portability of benefits (*i.e.*, benefits available when temporarily absent from the home province), and public administration.

Federal financial contributions to participating provinces became payable from July 1, 1968, and are based on half of the national average per capita cost of insured services of the national program, excluding administration, multiplied by the average number of insured persons in each province. All provinces were participating by January 1, 1971.

The standards embodied in the federal act require that provincial programs must cover all medically necessary services by a physician or surgeon. There can be no dollar limits or exclusions except on grounds that the services were not medically required. The program must be universally available to all eligible residents of a participating province on equal terms and conditions, and cover at least 95 percent of the total eligible population. Benefits must be portable, so that an insured person would retain coverage when temporarily absent from his own province or moving from one province to another.

As of the end of 1974, four of the ten provinces finance their share of the cost of their program partly by premiums or special taxes; the other six provinces finance their share from general taxes, with care available to all residents.

All provinces cover without limit the services of psychiatrists in the hospital, office, home, or clinic. None of the provinces pay for the services of psychologists under their insurance programs.

All provinces, apart from the insurance program, maintain mental hospitals and mental clinics (in which services are provided by psychiatrists, psychologists, social workers, psychiatric nurses, etc.), the services of which, to all practical purposes, are free to all residents. Hence, to the extent that personnel and facilities are available, complete care for mental or emotional illness may be said to be freely available.

All plans provide the insured services of the federal program, *i.e.*, medically required services of medical practitioners and certain surgical-dental procedures undertaken by dental surgeons in hospitals. Several of the programs provide extra and explicitly defined benefits, the costs of which are not shared by the federal government. Among these, in one province or another, are optometry, chiropractic, podiatry, and osteopathy services.

All plans pay private practitioners according to a fee schedule negotiated with the provincial medical society. Other modes of payment are permissible, and some

doctors are paid by capitation, session, or salary arrangements. Physicians under the fee mode submit claims to and are paid directly by the provincial administrative agency, except that in a few provinces private agencies play a role in the transmission and payment of claims. Physicians who do not wish to accept payment at the scheduled rate have the alternative of billing the patient, providing the latter agrees to this in advance. In such a case the patient files the claim, and the benefit at the allowed fee is paid to him, and he is responsible for any extra amount owed the doctor. This occurs in only a small percentage of cases. In the past one province for a number of years required patients to pay certain so-called utilization fees (a dollar or two) for each office or home call. Such charges were terminated in August 1971.

Letters were written in June 1974 to the heads of the medical insurance programs (in a number of the provinces the administrations of the hospital and medical insurance programs have now been unified under a single agency) requesting a copy of the latest annual and statistical report on the program, together with any unpublished information that was available on utilization of care for mental conditions. Replies were received from all provinces and some utilization data were available from all except one.

Table 2 shows for all provinces for which data were available the covered population, the total number of medical services per 1,000 covered population, total fee payments to physicians¹ for medical services per person covered, total psychiatric services per 1,000 population, total payments for psychiatric services per person covered, and the percent of psychiatric services and payments to total services and total payments. Psychiatric services are those denominated as such in the province's fee schedule, *e.g.*, consultation, examination, and evaluation, individual, family, and group psychotherapy, electroconvulsive therapy, psychological testing. A few provinces, it appears from the provincial reports, do not pay general practitioners for psychotherapy; in such cases, any office visit to a general practitioner in which the main service was diagnosis or care of a patient whose problem appeared to be mainly or entirely mental or emotional would not be included in the statistics on psychiatric services. However, most provinces do pay general practitioners for psychotherapy and possibly other psychiatric services as well, and in some provinces as much as 30 or 40 percent of all psychiatric services are rendered by general practitioners who receive a substantial percentage of the total payments for psychiatric services. For example, in Ontario, 28 percent of the total payments for psychiatric services went to general practitioners, in Quebec 27 percent, in Alberta 31 percent, and in Saskatchewan 27 percent.

In general, the table shows only services paid for by fee payments. Amounts paid as salaries or as "sessional"

¹In a few provinces this amount may include payments to dental surgeons. The amount is insignificant.

TABLE 2
Utilization of Psychiatric Services and Payments for Such Services
Under Canadian Provincial Programs of Medical Care Insurance, 1971-73

Province	Year to which data relate	Covered population (insured persons)	Total number of medical services per 1,000 covered population	Total fee payments for medical services per covered person	Total psychiatric services per 1,000 covered population	Total fee payments for psychiatric services per covered person	Psychiatric as a percent of total services	Psychiatric as a percent of total payments
British Columbia	4/1/72-3/31/73	2,268,935	7,646	\$60.30	113	\$2.01	1.5	3.3
Alberta	7/1/72-6/30/73	1,764,757	6,557	56.22	160	1.99	2.4	3.5
Saskatchewan	1973	880,295	7,421	48.35	131	1.50	1.8	3.1
Manitoba	1973	1,027,800	8,210	57.37	368 ^a	2.81 ^a	4.5 ^b	4.9 ^b
Ontario	4/1/72-3/31/73	8,226,720	NA	55.54	327	3.15	NA	5.4
Quebec	1973	6,081,476	6,278	55.05	151	2.37	2.4	4.3
New Brunswick	1971	630,700	2,957	31.71	29	.43	1.0	1.3
Nova Scotia	4/1/71-3/31/72	776,000	5,332	39.99	55	.56 ^c	1.0	1.4 ^c
Prince Edward Island	4/1/72-3/31/73	113,000	NA	39.02	NA	NA	NA	NA
Newfoundland	4/1/72-3/31/73	534,000	2,807 ^d	31.99	NA	1.12 ^e	NA	3.5
Yukon	4/1/72-3/31/73	18,000 ^f	—	—	—	—	—	—
Northwest Territories	4/1/72-3/31/73	3,800 ^f	—	—	—	—	—	—
Canada	4/1/72-3/31/73	21,803,621 ^g	—	—	—	—	—	—

^aData for 1972.

^bComparison of 1972 data on psychiatric services and costs with 1973 data for all services tends to understate the proportion of psychiatric to total.

^cHowever, other data indicate total payments to psychiatrists of \$7.75 per covered person, equal to 1.8 percent of all payments under the program.

^dExcluding salaried services.

^ePayments on fee-for-service basis only. If salaried payments to psychiatrists at provincial mental hospitals are included the cost is \$2.21 per capita.

^fNo attempt was made to get utilization data for these territories.

^gAverage number of insured persons during year April 1, 1972-March 31, 1973, as reported by the National Department of Health and Welfare (*Annual Report for Fiscal Year 1973 Respecting Operations of the Medical Care Act*). The figures given for the individual provinces are not additive.

payments to medical practitioners are in general not included—though such payments are shared by the federal government. Generally the number of services rendered by physicians paid on this basis is not known.

The total number of psychiatric services per 1,000 covered population may not be comparable from one province to another, since there is some variation in definitions of services paid for at scheduled fees. For example, Manitoba pays for psychotherapy on the basis of one-quarter-hour units; thus a 60-minute session would be counted as four services. However, the dollar payments are in general comparable.

It will be seen from the table that the number of psychiatric services per 1,000 population in the eight provinces for which data were available ranged from 29 to 368. The payments for these services per covered (insured) person ranged from \$4.3 in New Brunswick to \$3.15 in Ontario. Mainly the data are for the year 1973 or for a fiscal year ending in 1973. The number of psychiatric services constituted a relatively small proportion of the number of all services, ranging from 1.0 to 4.5 percent. The latter percentage is for Manitoba; the upper figure is 2.4 percent if Manitoba is excluded. The payments for psychiatric services ranged from 1.3 to 5.4 percent of the total for all medical services.

All these statistics on number of and payment for psychiatric services are exclusive of services provided by salaried physicians in the mental hospitals, clinics, and mental health centers maintained by the various provinces.

The variation in utilization of all physicians' services and of psychiatric services is due to a considerable number of factors, among which the supply of physicians and of psychiatrists in relation to the population is important. Table 3 shows the number of physicians in each province in 1972, the population per physician, the number of psychiatrists (whether salaried or in private practice), and psychiatrists as a percent of all physicians.

Canada has a somewhat smaller number of physicians in relation to population than the United States—633 persons per physician in 1972 as against 623 in the United States.² However, the proportion of all physicians who are psychiatrists is considerably higher in the United States than in Canada—7.4 percent as against 4.0 percent in Canada. (These figures may not be fully comparable since the number of psychiatrists in Canada

²Distribution of Physicians in the United States, 1972, American Medical Association.

Number of Physicians and Psychiatrists in 1972,
by Province

	Physicians	Ratio of physi- cians to pop.	Psychi- atrists	Psychi- atrists as a % of all physicians
Canada	34,508	1: 633	1,376	4.0
Newfoundland	504	1:1,056	16	3.2
Prince Edward Island	105	1:1,076	2	1.9
Nova Scotia	1,147	1: 692	43	3.7
New Brunswick	656	1: 979	11	1.7
Quebec	9,677	1: 626	468	4.8
Ontario	13,364	1: 556	551	4.1
Manitoba	1,573	1: 631	52	3.3
Saskatchewan	1,140	1: 804	24	2.1
Alberta	2,444	1: 677	63	2.6
British Columbia	3,850	1: 584	145	3.8
Yukon	16	1:1,181	0	—
Northwest Territories	31	1:1,250	0	—
Province unspecified	1	—	0	—

Source: Canada, *Health Manpower Inventory, 1973*. Department of National Health and Welfare, pp. 110-154.

includes only those who are board certified, while this is not the case in the United States.)

In conclusion, it may be stated that the Canadian provincial programs of medical service insurance cover the psychiatric services on the same basis as all other medical services and that the annual payments for psychiatric services range from \$5.43 to \$3.15 per covered person and constitute 1.3 to 5.4 percent of total payments for all medical services.

These payments are, it should be well understood, exclusive of the expenditures made by the provinces in maintaining their mental hospitals and community mental health centers and clinics.

More detailed descriptions of the provincial medical care insurance programs and more detailed statistics on utilization experience follow. (The provinces are listed from west to east.)

British Columbia

The province has an overall Medical Services Plan which operates under the supervision of the Medical Services Commission. The plan covers all residents who pay the required premiums. There are three licensed carriers, British Columbia Medical Plan, C. U. & C. Health Services Society, and Medical Services Association. During the year ended March 31, 1973, an average of 2,268,935 persons were covered.

During the year ended March 31, 1973, a total of 17,348,268 services were paid for through fee-for-service payments, equal to 7.646 services per 1,000 population covered. Total payments for these services amounted to

\$4,556,869 in payments were for psychiatric services, i.e., psychotherapy, psychiatric consultations, electroencephalography, etc.,⁵ equal to 113 services per 1,000 covered population and \$2.01 per covered person, and to 1.5 percent of total services and to 3.3 percent of total payments.

Of the psychiatric services and payments, 98 percent in both cases were for services rendered by psychiatrists, with almost all of the rest being for services rendered by neuropsychiatrists. Only a handful—506 services costing \$4,587—were for services rendered by general practitioners.

The breakdown of psychiatric services by type of service was as follows:

Type of service	Services	Payments (cost)
Subsequent hospital visits	30,592	\$ 137,548
Consultations—office, home, or hospital	25,531	769,481
Electroencephalography	9,961	89,629
Psychotherapy	172,155	3,324,100
Consultations—emotionally disturbed children	3,099	154,152
Group therapy	15,183	81,958
Total	256,521	\$4,556,869

During the 1972-73 fiscal year there were 91 active psychiatrists, i.e., those who received more than \$20,000 in fee payments during the year. The average payment per psychiatrist was \$41,974. This average payment was lower than that for general practitioners and for all but two or three other specialties—perhaps this was because some of the psychiatrists received income from salaried work.

The salient items in the fee schedule for psychiatric services, effective June 1, 1974, were as follows:⁶

Item	Fee
Consultation (office, home, or hospital)—to include complete history and assessment with written report	\$40.00
Consultation re emotionally disturbed child	74.00
Continuation of psychotherapy (office or hospital, with or without disinhibiting agent):	
for 15 minutes	8.50
for 30 minutes	17.00
for 45 minutes	25.50
for 60 minutes	34.00
Subsequent hospital visit	6.00
Group therapy, per person per session	9.00

⁵Does not include payments for special nursing, Red Cross, chiropractic, naturopathic, physical therapy, podiatry, optometry, and other nonmedical services.

⁶*Annual Report for the Year Ended March 31, 1973*, Medical Services Commission of British Columbia.

⁷Data furnished in a letter dated June 24, 1974, from Caroline DeLozier, Medical Services Commission of British Columbia.

⁸Ibid.

The Commission payments are at the rate of 97 percent of the above fees. (Note: The above fees are higher than those paid during the 1972-73 fiscal year of the program.)

The above utilization data refer only to services provided by private practitioners on a fee-payment basis. They are exclusive of services provided by salaried personnel in the province's mental hospitals and mental health centers and clinics. During the year 1972 there was a total of 6,647 patients admitted to the province's 25 mental health centers.⁷

Alberta

The Alberta program of medical service insurance began operation in 1969. The program is administered by the Alberta Health Care Insurance Commission, and is financed partially by premiums which must be paid by all residents. The total number of persons covered as of June 30, 1973, was 1,764,757.

The total number of medical services provided on a fee-for-service basis in the year ending June 30, 1973, was 11,571,241—equal to 6,557 services per 1,000 covered population. Total fee payments for services were \$99,221,669, or \$56.22 per person covered.⁸

The total number of psychiatric services provided during the year (including only those provided on a fee-for-service basis) was 283,155—160 per 1,000 covered population—and the total fee payments for these services were \$3,511,304, equal to \$1.99 per covered person. Psychiatric services numbered 2.4 percent of all services, and payments for such services amounted to 3.5 percent of the total payments under the program. Of the total psychiatric services, 47 percent were rendered by nonspecialists, i.e., general practitioners, and 30.7 percent of the payments were to these practitioners.

A breakdown of psychiatric services and payments by type of service⁹ is provided in Table 4.

⁷1972 Statistical Report of Mental Health Branch, British Columbia Department of Health.

⁸Annual Report for the Year Ended June 30, 1973, Alberta Health Care Insurance Commission.

⁹Data provided by the Commission in a letter dated June 21, 1974.

The total number of psychiatrists to whom payments were made in 1973 was 72. These comprised 3.3 percent of the total number of medical practitioners to whom payments were made. The average payment per psychiatrist was \$34,718 compared to \$44,998 for all practitioners. (The relatively low average payment per psychiatrist may be due to the fact that some of them rendered services on a salaried basis in provincial mental hospitals and clinics.) Of the 72 psychiatrists, 11 received payments of less than \$10,000, 14 received \$10,000 to \$19,999, 15 received \$20,000 to \$39,999, 25 received \$40,000 to \$59,999, and seven received payments between \$60,000 and \$79,999.

Total payments to psychiatrists were \$2,449,672, equal to \$1.39 per covered person, and represented 2.5 percent of total payments to all medical practitioners.

The more important items in the schedule of fees payable for psychiatric services were as follows:

Item	Fee
Fees payable to psychiatrists¹⁰	
Consultation, formal, major, per hour	\$28.00
Initial visit, requiring complete examination and investigation, per hour	28.00
Electroconvulsive therapy, each treatment	10.00
Individual psychotherapy or narcoanalysis:	
1 hour	28.00
½ hour	14.00
Each subsequent ¼ hour	7.00
Group psychotherapy:	
Adults—1½-hour session per person (maximum of \$22 per ½ hour)	8.00
Family—1½-hour session	40.00
Fees payable to nonpsychiatrists	
Psychotherapy (when appointment is made specifically for this purpose):	
First ½ hour	10.00
Subsequent quarter hours, each	5.00
Group psychotherapy:	
Adults—1½-hour session, per person (maximum \$22 per ½ hour)	6.00
Family—1½-hour session	30.00

¹⁰Fee schedule as of November 1, 1972.

TABLE 4
Psychiatric Services Provided by Specialist and Nonspecialist Physicians, by Type of Service, Alberta

Type of psychiatric service	By certified specialist		By nonspecialist		Total	
	Number of services	Amount paid	Number of services	Amount paid	Number of services	Amount paid
Consultations	8,341	\$ 211,958	—	—	8,341	\$ 211,958
Initial visits	5,729	156,417	—	—	5,729	156,417
Electroconvulsive therapy	6,895	68,918	1,165	\$ 11,639	8,061	80,557
Individual psychotherapy	116,117	1,849,303	129,717	1,037,374	245,834	2,886,677
Group psychotherapy	12,556	145,503	1,698	25,527	14,254	171,030
Hypnototherapy	—	—	936	4,665	936	4,665
Total	149,639	\$2,432,099	133,516	\$1,079,205	283,155	\$3,511,304

It should be emphasized that the above services and payments are exclusive of those rendered at provincial mental hospitals and institutions by salaried physicians.

Saskatchewan

The Saskatchewan Medical Care Insurance program has been in operation since 1962. In 1973 the program covered 880,295 persons. Services for mental conditions are covered on the same basis as services for all conditions. The program during 1973 was financed by premiums (\$12 per single person and \$24 for a family), general taxes, and the federal contribution. Effective January 1, 1974, premiums were discontinued. The program is administered by the Saskatchewan Medical Care Insurance Commission.

In 1973 the total number of services for all conditions (including surgical operations, office, home, and hospital visits, laboratory services, diagnostic procedures, etc.) numbered 6,533,100 or 7,421 per 1,000 beneficiaries, and total payments for services amounted to \$42,564,000, or \$48.35 per beneficiary.¹¹ Almost all services are paid directly by the Medical Care Insurance Commission or through approved health agencies at fees which the practitioner agrees to accept as full payment for his services.

The Commission's annual report does not show the total number of psychiatric services and payments and it is necessary to approximate these by combining certain data for general practitioners and psychiatrists. The report states that the number of psychotherapy services (defined as treatment interviews, group therapy, and counseling) in 1973 was 76,200, or 86 per 1,000 covered population. Payments for psychotherapy amounted to \$764,000, equal to \$8.7 per covered person. Of all psychotherapy services, 49.4 percent were rendered by general practitioners, and they received 47.6 percent of the total payments for these services. Hence it may be calculated that general practitioners provided 37,643 psychotherapy services and received \$363,664 in payment for such services.

Special data provided by the Commission indicate that in 1973 the number of services provided by psychiatrists was 77,305—88 per 1,000—and the total payments to psychiatrists were \$960,362 or \$1.09 per beneficiary.¹² Adding to these figures the number of psychotherapy services provided by general practitioners and payments for such services, one may conclude that the total number of psychiatric services was 114,948 and the total payments for them \$1,324,026. The services are equal to 131 per 1,000 covered population and the payments are equal to \$1.50 per covered person and comprise, respectively, 1.8 percent and 3.1 percent of the total services and payments. Of the total payments for psychiatric services, 27 percent went to general practitioners.

Among the services rendered by psychiatrists the following are some of the more significant items, in terms of amount of payments:

Type of service	Number of services	Amount paid
Specific assessment	8,175	\$206,972
Consultation	3,433	114,965
Hospital visit	13,435	47,213
Psychiatric social interview	4,913	60,955
Treatment interview:		
30 minutes	22,850	285,317
Additional time	9,258	48,319
Electroshock (with anesthesia)	3,399	42,419
Psychological testing	3,275	73,348

In 1973 there were 758 active physicians (physicians who received \$10,000 or more in commission payments in the province) of whom 466 were general practitioners and 292 were specialists, including 17 psychiatrists. The population per active physician was 1,161, and that per active psychiatrist was 51,782.

The distribution of psychiatrists by size of practice (number of different persons on whose behalf a claim was paid during the year) was as follows:

Size of practice	Number of psychiatrists
Less than 500 patients	9
500- 999 patients	5
1,000-1,499 patients	2
1,500-1,999 patients	1

The average number of patients per psychiatrist was 597 (compared with 1,898 for all physicians).

The average payment per active psychiatrist in 1973 was \$55,000. That for all specialists was the same, and that for all general practitioners was \$49,000.

Salient fees paid for psychiatric services are as follows:

Type of service	Specialist in psychiatry	
	Referred	Not referred
Visits:		
Specific assessment	\$26.00	\$20.80
Minor assessment and subsequent visit	8.00	6.40
Consultation	34.00	—
Psychotherapeutic visits—office, home, or hospital:		
Psychiatric social interview	12.75	10.20
Group therapy—per person	6.80	5.44
Maximum per session	51.00	40.80
Family psychotherapy:		
Two persons—per person	12.75	10.20
Three or more—per person	8.50	6.80
Treatment interview:		
30 minutes	12.75	10.20
Special procedures:		
Electroshock therapy—per treatment:		
Without anesthetist (includes visit fee)	17.00	13.60
With anesthetist (includes visit fee)	12.75	10.20
Psychological testing:		
Simple	17.00	13.60
Complex	34.00	27.20

It should be understood that the above per capita payments for psychiatric services do not include payments to psychiatrists and others under the province's

¹¹All data unless otherwise indicated are from *Annual Report 1973*, Saskatchewan Medical Care Insurance Commission.

¹²Letter dated June 28, 1974.

Mental Health Act which provides for a Department of Public Health, which operates the province's public mental hospitals and mental health centers.

The Department's Psychiatric Services Branch operates six full-time mental clinics, each serving a particular region, and 44 part-time clinics, and employed in 1972 approximately 43 psychiatrists.¹³ In 1972 the Psychiatric Services Branch saw 10,120 outpatients and another 1,865 were seen at the University Hospital. Total outpatient contacts, including those at the University Hospital, were 99,126. Total expenditures of the Psychiatric Services Branch, including maintenance of mental hospitals, services for the mentally retarded, outpatient care, and research, amounted to \$13,384,632 in the year ending March 31, 1973—equal to \$15.20 per capita over the entire provincial population.

The Director of the Branch stated that the full-time salaried service of the Branch provides the great majority of psychiatric services outside of the two main cities of Regina and Saskatoon.¹⁴

Manitoba

The medical insurance program, which began operation in 1969, covers all residents of the province, numbering 1,027,800 as of June 1, 1973. Premiums were discontinued May 31, 1973. The program is administered by the Manitoba Health Services Commission.

The total number of medical services (exclusive of oral surgery, podiatry, and chiropractic services) rendered under the program in 1973 was 8,438,559—\$210 per 1,000 population. Total value of these services was \$58,971,701, equal to \$57.37 per person covered.¹⁵

During 1973 there were 43 psychiatrists in the province who received payments under the program of more than \$10,000, *i.e.*, who were active in fee practice, equal to .042 per 1,000 population and constituting 4.2 percent of the total number of all active physicians, *i.e.*, those who received more than \$10,000 during the year. The 43 psychiatrists received an average payment of \$45,850 in 1973.

The fees paid for salient psychiatric services, as of 1974, were as follows:

During 1973 there were 316,835 services (each full 15 minutes of psychotherapy counted as a service, so that a full hour would be counted as four services) rendered by physicians registered as specialists in psychiatry. The total cost of these services was \$2,196,647, or \$2.14 per covered person. Of the total cost, 92.1 percent was for unreferred and 7.9 percent for referred services.

There were (if the statistics given are interpreted correctly) 24,576 different patients cared for by psychiatrists during the year, so that the average cost per patient was \$89.40. (The number of services and the cost of services include a relatively small number of services not of a psychiatric nature (e.g., anesthesia, surgery, X rays, radium) performed by psychiatrists mainly on referral from other physicians.

From the above it may be calculated that the total number of services performed by psychiatrists was 3.8 percent of the total number of medical services under the program, and the cost was 3.7 percent of the total for all medical services.

The above data refer to the services and cost thereof rendered by psychiatrists. Data for 1972 are available on utilization of services by major diagnostic groups. (This would include the services rendered by nonpsychiatrists and exclude the nonpsychiatric services rendered by psychiatrists.) In 1972, 373,305 services for "mental-psycho" diagnoses were rendered, with a total cost or value of \$2,863,629.^{16, 17} The number of services was equal to 368 per 1,000 population and the cost was equal to \$2.81 per covered person. (The number of services is not comparable with that for 1973, since in 1972 an hour of psychotherapy was counted as one service, but since February 1, 1973, would be counted as four services.) The total value of services rendered by psychiatrists in 1972 was \$1,767,719. The difference between \$2,863,629 and \$1,767,719 represents mainly the value of psychotherapy or other services rendered for mental conditions by general practitioners.

The above data for 1973 or 1972 do not include services (or value of services) provided by salaried physicians in provincially owned and operated mental hospitals or clinics.

Ontario

The province's medical insurance program began operation in 1969. In 1972 the hospital and medical insurance plans became a single plan administered by the Ontario Health Insurance Plan. The program covered 8,226,720 persons as of March 31, 1973.

	<u>Type of service</u>	<u>Fee</u>
Office visits		
	Complete history and psychiatric examination:	
	Adult	\$21.40
	Child	25.70
	Subsequent visit	6.00
Hospital care		
	Complete history and examination—same as above	
	Subsequent care: 1st and 2nd week, per day	5.15
	3rd and 4th week, per day	4.30
Psychotherapy		
	Individual per full 15-minute period (minimum duration ½ hour, maximum duration 1½ hours)	7.10
	Group (2 or more patients, maximum 8 patients) per full 15-minute period for the group—minimum duration ½ hour, maximum duration 1½ hours	10.05
Consultation		
	Adult	25.70
	Child	34.30

¹Annual Report for the Department of Public Health, April 1, 1972-March 31, 1973, Province of Saskatchewan, p. 72.

¹²Letter from C. M. Smith, M.D., June 18, 1974.¹⁵Annual Report 1973, Manitoba Health Services Commission.

¹⁶Statistical Supplement to the Annual Report of the Manitoba Health Services Commission for the Year 1972.

* Similar data are not yet available for 1973.

Total payments under the plan for medical services during the fiscal year April 1, 1972–March 31, 1973, were \$451,891,084 by month of service, equal to \$55.54 per person covered.¹⁸

Psychiatric services rendered during the same period and the amount paid for such services, as well as the Ontario Medical Association fee for each type of service, are shown in Table 5.¹⁹

It will be seen that the total number of psychiatric services rendered during this period was 2,518,556, equal to 327.0 services per 1,000 participants. Total payments for these services amounted to \$25,924,015, equal to \$3.15 per participant and 5.4 percent of total payments for all medical services.

Of the total psychiatric services, 30.7 percent were rendered by general practitioners, 64.4 percent by psychiatrists, and 4.9 percent by other physicians. Of the total payments for psychiatric services, 27.8 percent went to general practitioners, 68.4 percent to psychiatrists, and 3.7 percent to other physicians.

The fees paid to psychiatrists and general practitioners for psychiatric services during the period April 1, 1972–March 31, 1973, are shown in the table. An overall fee increase of 7-3/4 percent became effective May 1, 1974. The percentage increase varied among specialty groups—some specialties had more than a 7-3/4 percent increase, some less.

Quebec

This plan has been in operation since January 6, 1971. It covers all residents of the province and is financed by general taxation and federal assistance. It is administered by the Quebec Health Insurance Board. The total population covered as of June 1, 1973, was 6,081,476.

The total number of psychiatric services (visits in the office, home, and hospital, consultations and treatments peculiar to the specialty) provided during 1973 (and paid for by March 31, 1974) was 919,547, or 2.4 percent of the total of all medical services (38,188,423).²⁰ The total cost of psychiatric services was \$14,411,480—equal to 4.3 percent of the total cost of all medical services (\$334,798,961). The number of psychiatric services was 151 per 1,000 population, compared with 6,278 for all medical services, and the cost was \$2.37 per covered person, compared with \$55.05 for all medical services.²¹

¹⁸Data from *Annual Report 1972* of the Ontario Ministry of Health. Payments by month of payment amounted to \$508,578.51 to \$62.49 per capita. Data by month of service are used since the data for psychiatric services are on that basis. Medical payments are exclusive of those for dental, optometry, chiropractic, osteopathy, and chiropody services. The Report does not give data on number of services.

¹⁹Data specially developed by the Plan.

²⁰All data are from 1973 *Annual Statistics*, Quebec Health Insurance Board, 1974. (This publication is the source for Tables 6-10.)

²¹Does not include dental oral surgery and optometry services.

The annual statistical report of the program of this province is very comprehensive and detailed. Some of the salient data will be given.

Table 6 shows the number and cost of psychiatric services provided by physicians per 1,000 beneficiaries, by age and sex. It will be apparent that the use of services by females was much higher than by males and that utilization and cost were low among children and adolescents, reached a peak in the 25-34 age group, and was low among those 65 and over.

The average cost per psychiatric service was \$15.67, which reflects in part the fee schedule (see below), which by U.S. standards seems relatively low. The variation in the average cost per service by age and sex is shown in Table 7. There is not much difference in the average cost per service as between males and females. The cost is lowest, in general, among children, gradually increases with age, and is highest in the 25-34 age group.

Of all psychiatric services, 29 percent were rendered by general practitioners and 71 percent by medical specialists, mainly, of course, psychiatrists (see Table 8). The analogous proportions of the cost of services were 27.4 percent and 72.6 percent, respectively. Approximately 96 percent of the number of services and their cost rendered by specialists were rendered by medical (as contrasted with surgical) specialists.

Table 9 shows the distribution of the services rendered by psychiatrists and the cost of these services according to type of service. In interpreting this table and comparing it with Table 8, it is evident that a small proportion of the services of psychiatrists are in fields other than that of their specialty.

Table 10 shows the distribution of psychiatrists according to amount of payment received under the program in 1973. It may be presumed that the psychiatrists receiving small amounts of payments—less than \$10,000—were only partially active or were mainly occupied in providing service on a salaried basis in the province's mental hospitals and clinics and were treating only a relatively few patients on a fee basis in private practice.

The fee schedule for psychiatry appears to be relatively low in comparison with fees commonly charged in the United States. The fees paid for certain salient services are as follows:

Type of service	Fee
Ordinary consultation	\$22.00
Major consultation (adult)	30.00
Office visits:	
Ordinary examination	5.00
Complete evaluation	20.00
Psychoanalysis (50 minutes)	25.00
Individual psychotherapy:	
30 minutes	12.00
50 minutes	18.00
Family psychotherapy (2 persons or more—50 minutes)	20.00
Group psychotherapy (4 persons or more—50 minutes) per person, a maximum of \$30 per hour	4.50
In-hospital visits, ordinary, per day	3.50
Electroshock therapy, per treatment	13.00

TABLE 5
Psychiatric Services Paid by the Ontario Health Insurance Plan
for Service Months April 1972-March 1973

Type of Service	Ontario Medical Association fee	Number of services			Utilization per 1,000 participants per year				Amount paid					
		G.P.	Psych.	Other	Total	G.P.	Psych.	Other	Total	G.P.	Psych.	Other	Total	
Office														
Partial assessment	\$6.00	108	27,278	119	27,505	0.014	3.542	0.014	3.570	\$581	\$146,595	\$529	\$147,705	
Specific assessment	25.00	42	6,560	113	6,715	0.005	0.851	0.013	0.869	897	145,733	2,398	149,028	
Specific reassessment	15.00	—	2,454	22	2,476	—	0.318	0.002	0.320	—	32,762	266	33,048	
Consultation	38.00	165	52,036	194	52,395	0.021	6.757	0.023	6.801	5,511	1,772,624	6,285	1,784,419	
Repeat consultation	20.00	—	1,727	17	1,751	0.000	0.224	0.001	0.225	126	30,846	274	31,246	
Subtotal		322	90,055	465	90,842	0.040	11.692	0.053	11.785	7,115	2,128,560	9,771	2,145,446	
Home														
Partial assessment	9.00	8	331 *	—	339	0.001	0.042	—	0.043	65	2,655	—	2,719	
Specific assessment	25.00	—	110	—	110	—	0.014	—	0.014	—	2,463	—	2,463	
Specific reassessment	15.00	—	49	—	49	—	0.006	—	0.006	—	604	—	604	
Consultation	38.00	1	177	—	178	0.000	0.022	—	0.022	34	5,963	—	5,997	
Repeat consultation	20.00	—	11	—	11	—	0.001	—	0.001	—	198	—	198	
Nights, Sundays, and holidays	4.00*	2	385	—	387	0.000	0.050	—	0.050	7	1,349	—	1,355	
Subtotal		11	1,063	—	1,074	0.001	0.135	—	0.136	106	13,232	—	13,338	
Special visit to emergency (effective September 1972)														
Partial assessment	9.00	1	76	—	77	0.000	0.009	—	0.009	5	598	—	603	
Specific assessment	25.00	—	62	—	62	—	0.008	—	0.008	—	1,225	—	1,225	
Specific reassessment	15.00	—	18	—	18	—	0.002	—	0.002	—	243	—	243	
Consultation	38.00	—	325	—	325	—	0.042	—	0.042	—	11,100	—	11,100	
Repeat consultation	20.00	—	8	1	9	—	0.001	0.000	0.001	—	144	18	162	
Emergency call with sacrifice of office hours	3.00*	—	13	—	13	—	0.001	—	0.001	—	35	—	35	
Nights, Sundays, and holidays	4.00*	—	97	—	97	—	0.012	—	0.012	—	349	—	349	
Subtotal		1	599	1	601	0.000	0.075	0.000	0.075	5	13,694	18	13,717	
Hospital														
Specific assessment	15.00	5	1,744	7	1,756	0.000	0.226	0.000	0.226	60	22,181	73	22,314	
Subsequent visits	5.50	889	277,981	1,557	280,427	0.115	36.101	0.201	36.417	4,167	1,372,009	6,743	1,382,919	
Specific assessment, first time	25.00	18	3,165	38	3,221	0.002	0.411	0.004	0.417	404	69,008	844	70,256	
Consultation	38.00	75	18,602	28	18,705	0.009	2.415	0.003	2.427	2,529	632,393	945	635,866	
Repeat consultation	20.00	9	1,386	8	1,403	0.001	0.180	0.000	0.181	162	23,419	136	23,717	
Subsequent visits	5.50	57	24,592	23	24,672	0.007	3.193	0.002	3.202	253	115,712	109	116,074	
Concurrent care	5.50	25	1,768	—	1,793	0.003	0.229	—	0.232	118	8,799	—	8,918	
Subsequent visits	5.50	—	7,157	6	7,163	—	0.929	0.000	0.929	—	33,422	30	33,452	
Subtotal		1,078	336,395	1,667	339,140	0.137	43.684	0.210	44.031	7,693	2,276,943	8,879	2,293,516	

TABLE 5 (Continued)

Type of Service	Ontario Medical Association fee	Number of services			Utilization per 1,000 participants per year				Amount paid					
		G.P.	Psych.		Total	G.P.	Psych.		Total	G.P.	Psych.		Total	
			Other				Other				Other			
Procedures														
Consultation on behalf of disturbed child—														
diagnostic interview with parents	25.00	16	2,988	13	3,017	0.002	0.388	0.001	0.391	348	62,673	213	63.	63.
Diagnostic interview with child	25.00	15	2,738	1	2,754	0.001	0.355	0.000	0.356	330	60,818	15	61.	61.
Assessment conference with parents	25.00	1	1,472	—	1,472	0.000	0.191	—	0.191	23	32,299	—	32.	32.
Subtotal		32	7,198	14	7,244	0.003	0.934	0.001	0.938	700	155,790	228	156.	156.
Psychotherapy														
Interview on behalf of patient														
Individual psychotherapy	13.50	40	4,717	16	4,773	0.005	0.612	0.002	0.619	456	57,294	192	57.	57.
Group psychotherapy	13.50	5,451	875,090	13,645	894,186	0.707	113,648	1,770	116,125	63,933	10,600,391	159,805	10,824.	10,824.
Group psychotherapy	2.75	446	88,970	441	89,857	0.057	11,554	0.056	11,667	1,067	220,106	1,084	222.	222.
Group psychotherapy	5.50	477	74,350	778	75,045	0.061	9,661	0.099	9,821	2,353	366,314	3,752	372.	372.
Family psychotherapy	16.00	339	37,548	660	98,539	0.044	12,067	0.084	12,795	4,616	1,303,404	9,307	1,407.	1,407.
Subtotal		6,753	1,140,707	15,540	1,163,000	0.874	148,142	2,011	151,027	72,475	12,637,509	174,141	12,884.	12,884.
Psychotherapy by general practitioners (G.P.)														
Individual psychotherapy	11.50	630,006	5,226	38,938	674,179	81.818	0.679	5.048	87,545	6,485,356	54,022	398,410	6,937.	6,937.
Group psychotherapy	1.25	38,824	177	20,815	39,816	5.042	0.022	2.701	7,765	46,121	199	24,105	70.	70.
Family psychotherapy	6.50	77,861	1,914	14,468	94,233	10.111	0.248	1.872	12,231	492,839	11,221	83,875	547.	547.
Diagnostic interview—parent or child	13.50	1,301	17	1,478	2,796	0.168	0.002	0.190	0.360	15,393	207	17,342	32.	32.
Subtotal		747,992	7,343	75,689	831,024	97.139	0.951	9.811	107,901	6,999,711	65,648	523,732	7,589.	7,589.
Electrotherapy	13.00	17,183	38,613	29,481	85,277	2.231	5.014	3.825	11,070	131,523	443,130	251,720	876.	876.
Detention	5.50	2	352	—	354	0.000	0.045	—	0.045	10	1,732	—	1.	1.
Grand total		773,374	1,622,325	122,857	2,518,556	100.425	210.672	15.911	327.008	7,219,288	17,736,238	968,489	25,924.	25,924.
*Extra.														

*Extra.

TABLE 6

Number and Cost of Psychiatric Services
per 1,000 Beneficiaries, by Age and Sex, 1973

Age	Male		Female		Total	
	Number	Cost	Number	Cost	Number	Cost
0-1	4	\$45	3	\$45	3	\$45
1-4	10	120	6	84	8	103
5-9	27	396	17	225	22	313
10-14	36	551	25	373	30	464
15-24	96	1,435	154	2,549	125	1,987
25-34	190	3,160	373	6,379	281	4,770
35-44	180	2,871	361	5,834	270	4,352
45-54	164	2,446	285	4,207	226	3,345
55-64	144	2,048	215	2,957	181	2,521
65+	83	1,092	127	1,633	108	1,401
Total	110	\$1,700	191	\$3,030	151	\$2,370

The cost of psychiatric services has increased since the initial year and the cost in relation to that for all types of medical services has also increased, as shown by the figures²² below:

Year	Cost of psychiatric services	Cost of all medical services	Percent psychiatric to total
1971	\$9,901,267	\$273,598,386	3.6
1972	12,136,798	301,473,503	4.0
1973	14,411,480	334,798,961	4.3

The reader is reminded that the above statistics relate only to services provided under the plan and do not include the services or cost of services provided by salaried personnel in the province's mental hospitals and community mental health clinics.

Quebec had 506 psychiatrists in private practice, *i.e.*, who received payments under the program, equal to 8.3 per 100,000 population. Total physicians rendering

²²1973 Annual Statistics, Quebec Health Insurance Board, 1974, Table Hp-4.

TABLE 7

Average Cost of Psychiatric Service
(Cost per Service), by Age and Sex, 1973

Age	Male		Female		Total
	Number	Cost	Number	Cost	
0-1		\$10.99		\$16.57	\$13.17
1-4		11.85		13.31	12.39
5-9		14.53		13.14	14.01
10-14		15.27		15.12	15.21
15-24		14.94		16.53	15.91
25-34		16.63		17.12	16.95
35-44		15.92		16.17	16.09
45-54		14.87		14.77	14.81
55-64		14.23		13.75	13.93
65+		13.16		12.83	12.94
Total		15.39		15.83	15.67

TABLE 8

Distribution of Psychiatric Services
and Costs by Type of Practitioners

	Services		Cost	
	Number	Percent	Amount	Percent
All physicians	919,457	100.0	\$14,411,480	100.0
General practitioners	266,982	29.0	3,952,071	27.4
Medical specialists	652,475	71.0	10,459,409	72.6
Medical specialists	652,475	100.0	10,459,409	100.0
Surgical specialties	9,440	1.4	123,736	1.2
Medical specialties	623,712	95.6	10,041,441	96.0
Laboratory specialties	19,257	3.0	293,740	2.8
Radiology specialties	66	a	492	a

^aLess than one tenth of one percent.

service under the plan numbered 8,216, of whom 3,681 were general practitioners and 4,535 specialists. Psychiatrists constitute 6.2 percent of all physicians active under the plan.

New Brunswick

The Medical Care Plan commenced operation on January 1, 1971. The program covers all residents, is administered by the Medicare Division of the Department of Health, and is financed by general taxes and the federal contribution. The covered population during the year 1971, the latest year for which comprehensive data are available, was 630,700.

During the year 1971, 1,865,268 services—2,957 per 1,000 population—were provided under the program by

TABLE 9

Distribution of Number of Services of
Psychiatrists and the Cost of These
Services According to Type of Service

Type of service	Services		Cost	Per-cent	Average cost per service
	Number	Per-cent			
Office visits	17,270	2.6	\$97,407	1.0	\$5.64
Home visits	188	a	1,767	a	9.40
Institutions	32,564	5.0	126,385	1.3	3.88
Total visits	50,022	7.7	225,559	2.3	4.51
Consultations	320	a	6,664	0.1	20.83
Diagnostic and therapeutic procedures	15,528	2.4	59,133	0.6	3.81
Surgical procedures	184	a	1,421	a	7.72
Other ^b	587,109	89.9	9,480,453	97.0	16.15
Total	653,163	100.0	\$9,773,230	100.0	\$14.96

^aLess than one tenth of one percent.

^bIncludes psychotherapy and other services peculiar to psychiatry.

TABLE 10
Distribution of Psychiatrists According to
Amount of Payment Under the Plan, 1973

Amount of payment	Number	Percent
\$0- 3,999	94	18.6
\$4,000- 9,999	108	21.3
\$10,000- 19,999	126	24.9
\$20,000- 29,999	68	13.4
\$30,000- 39,999	38	7.5
\$40,000- 49,999	27	5.3
\$50,000- 59,999	28	5.5
\$60,000- 69,999	9	1.8
\$70,000- 79,999	4	0.8
\$80,000- 89,999	2	0.4
\$90,000- 99,999	1	0.2
\$100,000-109,999	0	—
\$110,000-119,999	1	0.2
\$120,000 and over	0	—
Total	506	100.0

physicians who received fee payments for their services, at a total cost (fee payments) of \$20,002,025, or \$31.71 per covered person.²³

During 1971, 13,646 services were performed by psychiatrists in New Brunswick, who received fee-for-service payments—21.6 services per 1,000 covered population—and for which they received payment of \$222,069—\$35 per covered person. These payments were 1.1 percent of aggregate payments to all New Brunswick physicians.²⁴

In 1971, \$46,393 were paid to general practitioners for 4,919 psychiatric services (psychotherapy only).²⁵ (In 1972 this increased to \$82,447 for 7,958 services.) Hence, in 1971, the total psychiatric services paid for on a fee basis numbered 29.4 per 1,000 population and the total cost amounted to \$43 per covered person, equal, respectively, to 1.0 percent of the total number of services and 1.3 percent of total fee payments under the program. In addition, the program in 1971 paid \$48,050 to psychiatrists for their work in mental health clinics and in residency training programs, bringing total outlays for psychiatric services in 1971 to \$50 per covered person. These figures exclude salary payments to physicians employed by the provincial government in its mental health clinics and hospitals.

During 1971 the number of different persons who received some service from psychiatrists was 2,274. The number of services per patient was 4.92 and the average cost per patient was \$80.05.

²³New Brunswick Medicare Annual Report 1971-72 and Statistical Supplement 1971.

²⁴These data include only services provided by physicians residing in the province; a small number of services are provided by physicians residing outside the province.

²⁵Data provided in a letter dated June 27, 1974, from D. A. Bone, Director of Medicare.

Table 11 shows services rendered by psychiatrists receiving fee payments, and the cost of such services, by type of service.

The salient items in the fee schedule for specialists in psychiatry (as of February 1, 1972) were as follows:

Item	Fee ²⁶
Referred cases:	
Consultation at home, office, or hospital (to include written report)	\$30.00
First visit with complete examination, including psychiatric evaluation	30.00
Subsequent visits	5.00
Nonreferred cases:	
First office visit with complete examination	15.00
Subsequent visits	5.00
Psychotherapy, irrespective of site, per ½ hour	15.00

Nova Scotia

The program began operation in 1970. It is administered by the Medical Care Insurance Commission. The program covered all residents of the province—776,000 persons—during the year ending March 31, 1972, the latest period for which data are available.

During that year the program paid for 4,137,654 services rendered on a fee basis by physicians, at a total cost (payment to physicians) of \$31,032,133. The number of services equaled 5,332 per 1,000 population and the cost represented \$39.99 per covered person.²⁷

Psychiatric services paid for on a fee basis numbered 42,370—1.0 percent of all services, and the cost of these services was \$434,361—1.4 percent of the total for all services. These figures are exclusive of services rendered

²⁶Medicare paid 87 percent of the above fees.

²⁷Annual Report of the Medical Care Insurance Commission for the Year Ended March 31, 1972. Province of Nova Scotia.

TABLE 11
Total Cost of Psychiatric Services by Type
of Service and Frequency, All Psychiatrists, 1971

Type of service	Frequency		Cost	
	Number	Percent	Amount	Percent
Consultations	1,743	12.8	\$43,484	19.6
Complete exam	834	6.1	18,783	8.5
Office visit and regional exam	324	2.4	1,464	0.7
Hospital visit	2,529	18.5	34,042	15.3
Home, emergency, nursing home visit	21	0.2	156	0.1
Diagnostic, therapeutic procedure ¹	79	0.6	3,700	1.7
Psychotherapy ²	8,059	59.1	120,301	54.2
Others	57	0.4	139	0.1
Total	13,646	100.0	\$222,069	100.0

¹Includes subcoma insulin, coma insulin, lobotomy workup, and narcoanalysis.

²Includes electroconvulsive therapy.

by and payments to salaried physicians. Psychiatric services numbered 55 per 1,000 population and payments for them represented \$56 per covered person.

However, the annual report also states that in the fiscal year ending March 31, 1972, the program paid \$580,912 to 43 psychiatrists, an amount equal to \$75 per covered person and 1.8 percent of total payments under the program. The difference between the \$580,912 and \$434,361 mentioned above may represent salaried payments to physicians. (The program made total payments for salaried physician services of \$1,954,000.) Apparently the figures stated above do not include any payments to general practitioners for psychotherapy services.

The total number of physicians who received fee payments in 1971-72 was 941. The number of specialists in psychiatry who received fee payments was 43. The distribution of these by fee payments was as follows:

<u>Fee paid</u>	<u>Number of psychiatrists</u>
Under \$2,000	7
\$2,000- 9,999	16
\$10,000-14,999	5
\$15,000-19,999	4
\$20,000-24,999	1
\$25,000-29,999	4
\$30,000-49,999	5
\$50,000-59,999	1
Total	43

Newfoundland

This program began operation in 1969. It covers all residents, is financed by the federal contribution and general taxes, and is administered by the Newfoundland Medical Care Commission. The covered population in 1972-73 was 534,000. About half of the population receives "front-line" services from general practitioners in cottage hospitals and district practices on a salaried basis.

During fiscal year April 1, 1972-March 31, 1973, the number of services rendered under the program, excluding salaried services, was 1,499,019.²⁸ The total payments under the program amounted to \$17,083,712 or \$31.99 per capita. These payments included \$4,844,048 in salaries and "sessional" payments, and \$240,238 in fee payments for dental surgery.

There were 14 psychiatrists during the year who received fee payments of \$599,064 (\$1.12 per capita). In addition, salaried or other payments of \$1,264 were made to these psychiatrists, and salaried payments were made to psychiatrists at provincial mental hospitals in the amount of \$582,245, for a total psychiatric cost of \$1,182,573 or \$2.21 per capita.

²⁸Annual Report—1972-73, Newfoundland Medical Care Commission.

Dr. PATTERSON. Continuing with my statement. That is, the majority of health insurance plans now provide inpatient service, and clearly the U.S. health insurance market at large demands an inpatient benefit.

Second, individual States are already legislatively mandating inpatient mental health services in health insurance policies. For example, Senator Kennedy, your own State, Massachusetts, mandates 60 hospital-days in group health insurance, and Connecticut mandates 30 hospital-days in its State HMO-enabling legislation. HMO's, as well as private insurance carriers, fall under this requirement.

Third, HMO's maintain they can offer the same benefits as insurance companies but at a significantly lower price. In our view it is just as competitively advantageous to offer more benefits at the same price, and we feel that this additional benefit should be an inpatient mental health benefit.

Fourth and finally, the cost of such a benefit properly administered is nominal. As an example, and here I am speaking for the Group Health Association of Washington, GHA was the first to provide inpatient and outpatient mental health services as part of the basic benefit package. We are still the largest HMO providing comprehensive mental health services as a part of the basic benefit to 100,000 members. By January 1, 1977, we plan to provide alcoholism treatment, including detoxification, as a basic benefit to all our members. Our comprehensive mental health program includes inpatient care up to 30 days, 20 individual or 40 group psychotherapy visits, partial hospitalization, 24-hour emergency service, and an active consultation and education program, particularly working with our primary care physicians.

We have just completed a cost analysis for the year 1975. The present cost of these services including administration and other overhead expenses is 80 cents per member per month. Cost of patient benefit is 17 cents per member per month, and our hospitalization represents only 1.5 percent, 1½ percent, of GHA's total hospital expense. Even with the addition of alcoholism treatment services, including detoxification, we still feel we can keep total costs to under \$1 per member per month. Our current cost per treatment encounter is \$20, which compares quite favorably to both public, and other private, treatment resources.

In summary, we in the APA do not feel that requiring HMO's to provide inpatient mental health services as a part of the basic health service package puts the HMO at competitive disadvantage or at risk of insolvency. We strongly recommend their inclusion.

We also favor inclusion of alcoholism treatment services in the basic benefit package. The cost of providing this service is not excessive. It is my personal opinion that alcoholism is a much more treatable disease than once thought, and its treatment and prevention impacts quickly and visibly on reducing membership morbidity and mortality. This reduction more than pays for the cost of the program.

We welcome the opportunity to work with you to develop appropriate language in implementing our proposal, should this committee so recommend. I would be happy to answer any questions you might have.

Senator KENNEDY. Have you met with these other groups concerning figures and statistics? You heard me ask the representatives of

the AFL-CIO about the cost, and they mentioned, as I understood, that it was not so much existing costs but the cost for developing new programs in terms of HMO's. Have you gone with the group that is up with the various amendments, spelled out your various statistics, and challenged them on theirs?

Dr. PATTERSON. Not at this point.

Senator KENNEDY. Do you not think it would be worth while doing?

Dr. PATTERSON. Yes; I do.

Senator KENNEDY. Why do you not do it?

Dr. PATTERSON. I came late to the effort, to the American Psychiatric Association which contacted me recently, and I think the American Psychiatric Association is quite willing and quite interested in pursuing this.

Senator KENNEDY. I think it would be very worth while. One group says it cost this amount, and you have a different cost. We are trying to look at the various studies and do an evaluation.

They also talk about the elimination of the preventive dental services, and home health. Why should we not include those if we are going to continue including yours? What is your position on that?

Dr. PATTERSON. I think if there is a reasonable position relating to what should be required in basic benefit package. I think it is my personal view that the standard of the community ought to be the benchmark in terms of what is required of private insurers within the community versus the concept of what the physician is required to do in terms of its practice as compared to the standard in the community. I think that the standard of the community, now certainly substantiated by these studies and others, is that inpatient mental health service is required by the standard of the community across the country.

Senator KENNEDY. More so than dental, preventive dental care for children?

Dr. PATTERSON. Yes, sir. Standard in terms of what is insured now.

Senator KENNEDY. But not necessarily in terms of need?

Dr. PATTERSON. Definitely not. I think that certainly that distinction is certainly one that should be pointed out, that there is a difference between our position relating to what the need is, and certainly we are making clear that the mental health benefit that would be mandated in an HMO is not the full mental health benefit that ought to be mandated in a more comprehensive national health insurance proposal.

Senator KENNEDY. I would suggest that you get together with the group and also submit whatever additional information you have with regard to statistics, both existing programs and what cost is for startup programs, and get together with that group that is advocating the various changes and work that out with them in terms of the figures on it.

As you know, I am extremely reluctant to see a reduction in the packages, but these things come out in the financial situation. I think you have obviously developed a good deal of material.

I think whatever you can provide on that will be very useful. I think you should get together with that association. I would be glad to write them and put you together with them, if you have any difficulty doing it. I would urge that you do it and give us the benefit of whatever results you have.

We will include that as part of the record.

Dr. PATTERSON. Thank you.

[Information referred to may be found in the files of the subcommittee.]

Senator KENNEDY. I want to thank you for your appearance here.

Dr. PATTERSON. You are welcome.

Senator KENNEDY. The subcommittee stands in adjournment.

[Whereupon, at 11 :50 a.m., the subcommittee adjourned.]



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